No. 19-2137

WILLIAM MCGREW and ELAINE MCGREW,

Plaintiffs-Appellants,

vs.

EROMOSELE OTOADESE, M.D. and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.,

Defendants-Appellees

APPEAL FROM THE IOWA DISTRICT COURT IN AND FOR BLACK HAWK COUNTY THE HONORABLE KELLYANN M. LEKAR, JUDGE

AMENDED APPENDIX

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Relevant Docket Entries

Plaintiffs' Petition at Law	July 29, 2016
Plaintiffs' Designation of Experts	February 6, 2018
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Entry of Judgment and Verdict Form	March 7, 2019
Plaintiffs' Motion for New Trial	March 7, 2019
Plaintiffs' Supplemental Motion for New Trial	April 22, 2019
Order on Post-trial Motions	December 8, 2019
Notice of Appeal	December 26, 2019

IN THE DISTRICT COURT OF IOWA IN AND FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW)) NO
Plaintiffs, v.))
EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.))))))
Defendant.)

COME NOW the Plaintiffs, and for their cause of action against the

Defendants, state as follows:

PARTIES

1. Plaintiffs William and Elaine McGrew are husband and wife and reside in

Waterloo, Black Hawk County, Iowa.

2. Defendant Eromosele Otoadese is a medical doctor who practices in

Waterloo, Black Hawk County, Iowa.

3. Defendant Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. is

an Iowa Professional Corporation that at all times relevant employed Dr. Otoadese.

4. Defendant Driss Cammoun is a medical doctor who practices in

Waterloo, Black Hawk County, Iowa.

ALLEGATIONS OF FACT

5. In the summer of 2014, William McGrew began to experience occasional foggy vision in his left eye.

6. On July 25, 2014, Mr. McGrew went to see an ophthalmologist at Mauer Eye Center who found that Mr. McGrew had a cataract that may explain his foggy vision.

7. However, Dr. Mauer thought it appropriate to first rule out a vascular cause for his symptoms, so the doctor ordered a bilateral carotid duplex ultrasound.

8. The carotid ultrasound was performed on August 6, 2014 and was interpreted by Dr. Mauer to show "mild carotid stenosis" of the arteries.

9. Dr. Mauer then proceeded to schedule cataract surgery for Mr. McGrew for approximately August 20, 2014.

10. In the interim, Mr. McGrew was referred by his primary care physician to Dr. Otoadese to determine if the problem he was experiencing was due to a vascular condition.

11. On August 18, 2014, Dr. Otoadese saw Mr. McGrew and ordered a CT angiogram.

12. The CT angiogram was performed on August 18, 2014 and was interpreted by Dr. Cammoun as showing 65% stenosis of the right internal carotid artery.

13. Dr. Otoadese then read and interpreted the CT angiogram to show severe (at least 70%) stenosis of the right carotid artery.

14. Dr. Otoadese was aware of the interpretation of the CT angiogram by Dr. Cammoun and relied upon it in deciding whether to recommend surgery.

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15. Dr. Otoadese then advised Mr. McGrew to cancel the cataract surgery and recommended a right carotid endarterectomy to remove the plaque in that artery.

16. Based on the recommendation made by Dr. Otoadese, Mr. McGrew agreed to undergo a right carotid endarterectomy.

17. The surgery was performed by Dr. Otoadese on September 2, 2014.

18. The morning following the procedure, Mr. McGrew awoke with a facial droop and weakness on his left side.

19. An MRI was performed which showed a stroke on the right side of the brain.

20. Dr. Otoadese then returned Mr. McGrew to the operating room in an effort to re-vascularize the area, but that effort was not successful.

21. The stroke suffered by Mr. McGrew was a direct result of the surgical procedure recommended and performed by Dr. Otoadese.

22. On September 26, 2014, Mr. McGrew was seen by Dr. Ivo Bekavac, a Waterloo neurologist, for a second opinion regarding his condition.

23. Dr. Bekavac, who has special training in interpreting imaging related to carotid arteries, examined Mr. McGrew and reviewed the pre-surgery imaging, and concluded that there was insufficient pre-surgery carotid stenosis to justify the September 2, 2014 surgery.

24. Dr. Bekavac also concluded that the second surgery was not indicated as the symptoms of the stroke had occurred more than 8 hours before.

25. Dr. Bekavac then sent the imaging studies to Dr. John Halloran, a Waterloo diagnostic radiologist, and asked him to review them to determine whether he concurred with Dr. Bekavac's interpretation of the imaging studies.

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26. Dr. Halloran's review of the pre-surgery imaging confirmed Dr. Bekavac's conclusion that there was not sufficient evidence to justify the recommendation and performance of the September 2, 2014 surgery.

27. The surgery of September 2, 2014 was an unnecessary surgical procedure that unnecessarily placed Mr. McGrew at substantial risk for the stroke that he eventually developed.

28. The interpretation of the pre-surgery imaging studies by Dr. Cammoun and Dr. Otoadese were incorrect, and the decision to recommend surgery by Dr. Otoadese was also wrong.

29. The Defendants failed to provide that degree of skill, care, and learning ordinarily possessed and exercised by other doctors, specialists, and hospitals in similar circumstances.

30. The Defendants' conduct constitutes medical negligence and breach of fiduciary duty, including lack of informed consent.

31. The conduct of the Defendants was a cause of the injuries and damages sustained by Plaintiffs.

COUNT I

1. Plaintiff William McGrew has sustained harms and losses, including, but not limited to, past and future physical and mental pain and suffering, permanent loss of full body, medical expenses, future medical expenses and loss of income.

William McGrew's damages exceed the jurisdictional requirements of Rule
 6.105 of the Iowa Rules of Appellate Procedure.

WHEREFORE, Plaintiff William McGrew prays for judgment against the Defendants for a reasonable amount of actual damages sufficient to fully compensate him and for interest and costs as provided by law.

COUNT II

1. Plaintiff Elaine McGrew has sustained harms and losses, including, but not limited to, the loss of services, support, companionship, society, and consortium of her husband.

2. Plaintiff Elaine McGrew's damages exceed the jurisdictional requirements of Rule 6.105 of the Iowa Rules of Appellate Procedure.

WHEREFORE, Plaintiff Elaine McGrew prays for judgment against the Defendants for a reasonable amount sufficient to fully compensate her and for interest and costs as provided by law.

Respectfully submitted,

MARK L. CHIPOKAS PC

By: /s/ Mark L. Chipokas Mark L. Chipokas, AT0001418 866 First Avenue NE P.O. Box 1261 Cedar Rapids, Iowa 52406-1261 (319) 366-7888 (888) 466-1350 Fax E-mail: mark@mlchipokaspc.com MARTIN DIAZ LAW FIRM

<u>/s/ Martin A. Diaz</u> Martin A. Diaz 000009676 ICIS AT0002000 528 South Clinton Street Iowa City IA 52240-4212 319-339-4350 319-339-4426 fax <u>marty@martindiazlawfirm.com</u> Attorneys for Plaintiffs IN THE DISTRICT COURT OF IOWA IN AND FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW
Plaintiffs, v.
EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.
Defendant.

Case No. LACV130355

PLAINTIFFS' DESIGNATION OF EXPERTS

COME NOW the Plaintiffs and hereby designate the following persons

who may be called as expert witnesses at the time of trial in the above

referenced matter:

 Dr. Carl Warren Adams 101 Becket Lake Dr. @ Celadon Durango, CO 81301-8853

Dr. Adams is a Board Certified Cardiovascular and Thoracic Surgeon including Trauma and Surgical Critical Care. Dr. Adams will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

Dr. Adams' education, training, experience, and qualifications to testify as an expert witness are set forth in his curriculum vitae which is being provided to counsel. 2. Dr. Ivo Bekavac 1735 W. Ridgeway Ave., Suite 112 Waterloo, Iowa 50701

Dr. Bekavac is a Board Certified Neurologist, with Subspecialty Board Certification in Vascular Neurology and Neuroimaging (among others) who, as a treating physician, will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; the harm sustained by Bill McGrew; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse. He will also be asked to comment on the evaluation, care and treatment he has provided to Bill McGrew since he sustained the stroke on September 2-3, 2014.

Dr. Bekavac's education, training, experience, and qualifications to testify as an expert witness are set forth in his curriculum vitae which has been provided to counsel.

Dr. John Halloran
 1825 Logan Ave.
 Waterloo, Iowa 50701

Dr. Halloran is a Board-Certified Neuroradiologist who will be asked to comment on the evaluation of imaging studies on Bill McGrew that he reviewed at the request of Dr. Bekavac. He will also be asked to comment on the standard of care in the imaging evaluation of an individual like Bill McGrew, any breach of that standard of care, and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse. A professional summary of Dr. Halloran's education, training, experience, and qualifications to testify as an expert witness can be found at the website for UnityPoint Health: <u>www.unitypoint.org/waterloo</u>. A CV may be provided later.

Kent Jayne
 502 Augusta Circle
 North Liberty, Iowa 52317

Mr. Jayne is a Certified Life Care Planner, vocational rehabilitation specialist and an economist who has been asked to develop a life care plan for Bill McGrew and can then testify to the amount of money needed to fund that life care plan. Depending on how the court rules on the issue of a lien for medical expenses, he may be asked to determine what medical bills are related to the injuries and damages sustained by Bill McGrew due to the negligence of the defendants.

Mr. Jayne's education, training, experience, and qualifications are as set forth in his curriculum vitae, which is being provided to counsel.

The following witnesses are "experts" in that they have scientific, technical or other specialized knowledge. However, these individuals (like Dr. Bekavac and Dr. Halloran) have not been retained in anticipation of litigation, and their expert opinions, if any, have not been developed in anticipation of litigation, but rather arise from the fact that these individuals may be treating physicians to the Plaintiff or have such other connection to this litigation that they are fact witnesses with specialized expertise.

5. All of Bill McGrew's treating health care providers as disclosed in the

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discovery process. This includes all individuals disclosed in depositions including the defendants.

6. All other providers of services, assistive devices, educational care, custodial care and rehabilitative care as disclosed in the discovery process.

 Plaintiffs reserve the right to call any other treating health care provider to testify to Bill McGrew's health history and potentially to causation and damages.

8. Plaintiff reserves the right to utilize, as experts, those individuals designated by the defendants in their designation to the Court.

9. Plaintiff reserves the right to call any rebuttal expert witnesses to any expert witness designated by defendants that raise issues otherwise not anticipated or expected.

Respectfully submitted,

MARK L. CHIPOKAS PC

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<u>/s/ Martin A. Diaz</u> Martin A. Diaz 000009676 1570 Shady Ct NW Swisher, IA 52338 phone 319 339 4350 facsimile 319 339 4426 marty@martindiazlawfirm.com Attorneys for Plaintiffs

Copy to all counsel via EDMS

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW,)	
Plaintiffs,))	NO. LACV130355
)	PLAINTIFFS' BRIEF IN
VS.)	RESISTANCE TO MOTION FOR SUMMARY JUDGMENT
EROMOSELE OTOADESE, M.D.;)	
NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC,)	
P.C.; and DRISS CAMMOUN, M.D.,)	
Defendants		

COME NOW the Plaintiffs and hereby submit their Brief in Resistance to Dr.

Cammoun's Motion for Summary Judgment:

INTRODUCTION

This lawsuit arises out of a surgery to remove plaque (cholesterol buildup) from Bill McGrew's right carotid artery. Plaintiffs contend that the surgery was unnecessary and that as a result of this unnecessary surgery Bill McGrew was subjected to unnecessary risk resulting in his suffering a stroke caused by the unnecessary surgery.

There are two defendants in this case: Dr. Otoadese, the surgeon who recommended and performed the fateful surgery; and Dr. Cammoun, the radiologist who misread the CT angiogram that was relied upon by Dr. Otoadese in recommending surgery.

The issue before the court is Defendant Cammoun's motion for summary judgment based on the mistaken belief that plaintiffs have failed to produce an expert report as required by Iowa Rule of Civil Procedure 1.500(2)(b). Dr. Cammoun's argument then claims that, because an expert report has not been produced, Plaintiffs

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Cammoun does not demonstrate right carotid artery stenosis of 65%. Rather, Dr. Halloran contends that the correct reading of that CT angiogram is 32% and Dr. Bekavac contends that the correct reading of that CT angiogram is no more than 40%. Dr. Bekavac also opined that because the CT angiogram was misread there was no justification for the surgery that was performed on Mr. McGrew. Accordingly, Plaintiffs complied fully with the disclosure requirement of IRCP 1.500(2)(c).

Defendant's contention that Plaintiffs were obligated to provide an expert report pursuant to the retained expert disclosure rule is simply mistaken. Defendant concedes that Drs. Bekavac and Halloran were treating physicians. As such, Plaintiffs had no obligation to obtain a written report from each. In fact, that's contrary to the entire framework of the disclosure requirements. The intent and purpose of the rules is to recognize that, when it comes to treating physicians, Plaintiffs have little to no control over those individuals. That is totally different than the scenario in which Plaintiffs go out and hire or retain an expert for the purpose of testifying at trial. In that scenario, Plaintiffs can obtain a report prepared by the retained expert. Treating physicians are not required to prepare special reports because they've not been retained for that purpose. Rather, treating physicians can rely upon any progress notes or medical records that they have generated themselves in the care and treatment of the plaintiff and can rely on the mental impressions they developed during the treatment process and any opinions formed from the facts obtained and impressions made.

The lowa rules recognize that treating physicians can develop mental impressions and opinions arising out of the care and treatment that they provide. That is certainly what happened here regarding Drs. Bekavac and Halloran. They are not

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW,		
Plaintiffs,	NO. LACV130355	
VS.	PLAINTIFFS' JURY INST	
EROMOSELE OTOADESE, M.D. and NORTHERN IOWA CARDIOVASCULAR		
AND THORACIC SURGERY CLINIC, P.C.		
Defendants		

COME NOW the Plaintiffs and submit the following proposed jury instructions for

consideration by this Court. Plaintiffs reserve the right to add, change or otherwise place

before the Court jury instructions after the taking of testimony or introduction of evidence.

Respectfully submitted,

/s/ Martin A. Diaz MARTIN A. DIAZ 000009676 ICIS AT0002000 1570 Shady Ct. NW Swisher, IA 52338 319-339-4350 telephone 319-339-4426 facsimile Attorney for Plaintiffs

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INSTRUCTION NO. 11

LOSS OF CHANCE OF A BETTER OUTCOME

If you find that the McGrews have failed to prove their claim for medical negligence as set forth in Instruction No. 8 and their claim for inadequate informed consent, you must then consider the McGrews' alternative claim for lost chance of a better outcome.

If you find that plaintiffs have proven either their claim of medical negligence or their claim for inadequate informed consent, you should not consider plaintiffs' alternative claim for lost chance of a better outcome.

In order to prove their claim for lost chance of a better outcome, the McGrews must prove all the following propositions:

1. Dr. Otoadese was negligent in failing to return Bill McGrew to surgery immediately upon learning that Bill was showing signs or symptoms of a stroke.

2. The negligence caused a loss of a chance of a better outcome.

3. The amount of damage.

If the McGrews have proved all these propositions, the McGrews are entitled to damages in some amount. If the McGrews have failed to prove any of these propositions, the McGrews are not entitled to damages on this claim.

ICJI 1600.16 (modified to fit case)

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE)
MCGREW,	
Plaintiffs,) NO. LACV130355
vs.	
) DEFENDANTS' MOTION IN
EROMOSELE OTOADESE, M.D.; and) LIMINE
NORTHERN IOWA CARDIOVASCULAR	
AND THORACIC SURGERY CLINIC, P.C.,	
Defendants	$\left \begin{array}{c} \\ \end{array} \right $
	()

Defendants Dr. Eromosele Otoadese and Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. (sometimes collectively "Dr. Otoadese") move, prior to selection of the jury and outside the presence of the jury for an Order prohibiting Plaintiffs, their witnesses, and attorneys from directly or indirectly making any statements, giving any evidence, or asking any questions during the selection of the jury, opening statements, presentation of the evidence (including cross examination of a witness called by Defendants), or closing arguments relating to the matters enumerated below until the Court has the opportunity to rule on the admissibility thereof. Defendants further move the Court to order Counsel to advise their clients and each witness called by them regarding the Court's limitation on evidence and testimony to this Motion. Defendants so move on the grounds that if the matters enumerated herein are mentioned it would be so prejudicial that Defendants would not receive a fair trial and an admonition to the jury would not cure the prejudice.

Defendants move in limine on the following:¹

¹ The following are attached:

Exh. 1 Report and Deposition of Plaintiff's expert Dr. AdamsExh. 2 Plaintiff Mr. McGrew Deposition

1. Any evidence regarding, or references to, an informed consent theory of recovery.

Plaintiffs' proposed instructions indicate the intent to introduce evidence regarding an informed consent claim as an alternative if the jury fails to find Dr. Otoadese negligent. Expert testimony is required for aspects of an informed consent claim which are beyond the common everyday knowledge of a lay jury—and Plaintiffs do not have the needed expert support for their informed consent theory. The claim is unsupportable and related evidence and references should be excluded under Rules 5.402 and 5.403. It would be unfairly prejudicial for Plaintiffs to expose the jury to a theory of recovery and plant seeds of doubt and suspicions about a theory that cannot survive.

Plaintiff William McGrew suffered a stroke after a carotid endarterectomy surgery performed on September 2, 2014 by Dr. Otoadese. Plaintiff's only expert, surgeon Dr. Adams, agrees that a stroke is a known complication of the surgery even when the surgery is performed without negligence. Exh. 1 at 13 (Dep. 39:9-21). There is no dispute that Mr. McGrew was informed prior to surgery of the risk of a stroke. Exh. 2 at 2 (Dep. 8:7-24). In addition to his deposition testimony, Mr. McGrew signed a consent form, indicating he had been told of the risks. There are no allegations in this case that Dr. Otoadese negligently performed the surgery.

Before the carotid surgery, Defendant radiologist Dr. Cammoun (who has settled with Plaintiffs) interpreted an August 18, 2014 diagnostic CT angiogram as showing 65% stenosis on the right and 60% stenosis on the left. *See* Exh. 1 at 2 (Adams report at 2). Dr. Otoadese, while not a radiologist and relying on Dr. Cammoun's interpretation, documented the stenosis as 70%

Exh. 3 Plaintiff Elaine McGrew Deposition

Exh. 4 Dr. Otoadese's deposition

Exh. 5 Dr. Bekavac's Sept. 26, 2014 record

Exh. 6 Dr. Halloran Oct. 1. 2014 record

Exh. 7 Plaintiff's 2nd Supp. Ans to Interrogatory No. 16, 12-18-18

²

on the right. Exh. 4 at 26 (Dep. 92:1-94:7). Dr. Otoadese recommended surgery. Exh. 4 at 27 (Dep. 96:24-97:16).

Plaintiffs' expert, Dr. Adams, disagrees that surgery was indicated. He opines that the surgery was not necessary because the CT angiogram (sometimes referred to as "CTA") did not show sufficient blockage in the carotid artery to warrant surgery. Exh. 1 at 3 (report at 3 ¶4: "Mr. McGrew did not meet surgical indications for right carotid endarterectomy ... as the stenosis was less than 40%."). Dr. Adams also opines that "[t]reatment is dual antiplatelet therapy (DAPT) and if surgical criteria is met, i.e., a stenosis of greater than 70% elective right carotid endarterectomy with patch is performed." Exh. 1 at 3 (report at 3, ¶3).

During his deposition, under examination by Plaintiffs' counsel, Dr. Adams was asked to assume he was the physician and then asked what he would tell the patient. Dr. Adams testified that because "there isn't anything documented on the CTA that would make me recommend surgery . . . I'd treat him with aspirin and Persantine or Plavix for anti-platelet therapy for three to six months and reevaluate." Exh. 1 at 16 (Dep. 51:17-52:7). In other words, Dr. Adams' opinion about alternative medication treatment is in the context of his view that the CT angiogram did not support surgery.

Dr. Adams does not opine or explain that--if Dr. Otoadese was correct in determining that surgery was necessary--then Dr. Otoadese still should have informed Mr. McGrew of an alternative to surgery. No where does Dr. Adams describe an alternative medication treatment as an available option if surgery is necessary. It is too late now for Plaintiffs to add more opinions from Dr. Adams.²

Plaintiffs' medical negligence jury instruction proposes that the jury could find:

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² See Iowa Rule 1. 508(3) (party must supplement expert disclosures "no later than 30 days before trial").

- 1. Dr. Otoadese was negligent in one or more of the following ways:
 - a. Misreading the amount of stenosis in the right carotid artery on the CT angiogram of August 18, 2014; OR
 - b. Performing an unnecessary surgery on Bill McGrew's right carotid artery on September 2, 2014

Plaintiffs' instruction No. 8.³ Plaintiffs propose that if they fail to prove the above that the jury could then consider the alternative claims for "inadequate informed consent . . . and loss of chance of a better outcome." *Id.* Plaintiffs' informed consent instruction proposes the claim as concerning "The existence of material information concerning an alternative to surgically removing ulcerated plaque in his right carotid artery." *Id.* at No. 10.

Plaintiff's informed consent theory is not supported by expert evidence. The claim is triggered only if Plaintiffs fail to prove Dr. Otoadese was negligent (in other words, if the jury finds Dr. Otoadese was right and surgery *was* necessary). Dr. Adams did not opine that when surgery is necessary that medication therapy is a reasonable alternative to offer the patient. There is no expert testimony about medication alternatives when surgery is necessary.⁴

Stated differently, if surgery was "necessary," how can there be an informed consent claim based upon the failure to tell the patient of an alternative to surgery? The surgery was either necessary or not; Mr. McGrew either met the surgical criteria or not. Submitting Plaintiff's alternative informed consent claim could lead to an inconsistent verdict.

To the extent Plaintiffs suggest they do not need expert testimony to support the informed consent claim, this is not the case. Notwithstanding "the patient rule," informed

³ Defendants do not suggest they agree with Plaintiffs' proposed instructions.

⁴ Submission of issues without evidentiary support constitutes error. *See Manno v. McIntosh*, 519 N.W.2d **8**15, 823 (Iowa Ct. App. 1994). "Proposed instructions must be supported by the pleadings and substantial evidence in the record." *Wolbers v. Finley Hospital*, 673 N.W.2d 728, 732 (Iowa 2003); *Kohles v. Mercy Health Serv.*, 2010 WL 3894447 *10 (Iowa Ct. App. 2010) (affirming trial court's refusal to instruct on specific allegation "because it concluded there was no expert testimony as to breach of standard of care or as to causation").

consent claims are established with expert testimony. See *Pauscher v. Iowa Methodist Med Ctr*, 408 N.W.2d 355, 360 (Iowa 1987)("the patient ordinarily will be required to present expert testimony relating to the nature of the risk and the likelihood of its occurrence,"); *see also Doe v. Johnston*, 476 N.W.2d 28, 31 (Iowa 1991) ("the burden rests with the plaintiff to establish by expert testimony the nature of the risk involved and the likelihood of its occurrence."); *Kennis v. Mercy Hosp. Medical Center*, 491 N.W.2d 161, 166 (Iowa 1992) ("Recently, we held that a claim of lack of informed consent is an issue beyond the common knowledge of laypersons and requires expert evidence;" referring to *Cox*); *Cox v. Jones*, 470 N.W.2d 23, 26 (Iowa 1991) ("without expert evidence, plaintiffs cannot show that defendants did not inform Cox of the existence of a material risk before undergoing the cataract removal operation").

While this case involves the alleged failure to provide material information as to an alternative to surgery rather than the risks of surgery, that does not change the need for expert testimony. In *Anderson v. Iowa Dermatology Clinic*, 819 N.W.2d 408, 416 (Iowa 2012) the Court analyzed a fraudulent concealment claim under informed consent law where the allegation concerned the failure to inform the patient about differences in qualifications between a dermatologist and board-certified pathologist in evaluating a specimen. The context was whether the patient would have chosen an alternative—a review by a pathologist—if given more information. *Id.* In this context, the Court found the plaintiff failed to provide sufficient expert testimony and failed to generate a fact issue. While the plaintiff provided an expert affidavit discussing differences in training, the expert did not "address the nature of the risk

or the likelihood of its occurrence" from having a dermatology review rather than pathology review. *Id.* at 417.⁵

Similarly, here, while Plaintiffs' expert Dr. Adams provides some opinion as to alternative treatments, he does *not* provide information upon which Plaintiffs' informed consent claim is based—that a medication alternative is an option when surgery is necessary. Nor does Dr. Adams provide any opinion as to the likelihood of risks—i.e. the comparison of risks of medication versus surgery for a patient who meets the surgery criteria. *See also Kennis*, 491 N.W.2d at 166 (discussing "comparative risk" in medical decision-making as "not so obvious as to be within the comprehension of a layperson"). A lay jury does not have the needed background to determine, without the assistance from expert testimony, the available alternatives to any given medical procedure or recommendation.

There is insufficient timely disclosed expert evidence to submit an informed consent claim and the claim could lead to an inconsistent verdict. Evidence about, and references to, such a claim should be excluded under Rules 5.402 and 5.403.

2. Any evidence regarding, or references to, a lost chance theory of recovery.

Plaintiffs' proposed instructions also reflect an alternative lost chance claim. This, like the alternative informed consent claim, is not supported by expert testimony and should be excluded. In addition, the lost chance claim was not pleaded and it is not supported under Iowa law.

In addition to Plaintiffs' claim that the carotid endarterectomy surgery was not necessary and should not have been performed, Plaintiffs claim that a second surgery—after Mr.

⁵ In *Doe*, the Court addressed a physician's obligation to offer a patient alternatives but did not discuss the need for expert testimony. 476 N.W.2d at 31-32. However, it was clear in *Doe* that there was indeed ample expert evidence on the available alternatives. *Id.* at 31 ("every physician testifying acknowledged . . . the known and available alternative").

McGrew's stroke symptoms occurred—"should have been performed immediately." Exh. 1 at 3 (Adams' report at 3 ¶6). In his deposition, Dr. Adams was asked about this opinion:

- Q: What specifically would have been different in Mr. McGrew's outcome if surgery would have been done earlier?
- A: To a reasonable degree of medical certainty and/or probability he would not have suffered a left hemispheric stroke.

Exh. 1 at 16 (Dep. 50:7-11).

The above is not an opinion to support a lost chance theory, but an opinion of traditional negligence. It is an "all or nothing" opinion; not an opinion supporting an alternative claim for lost chance. *See DeBurkarte v. Louvar*, 393 N.W.2d 131, 135 (Iowa 1986)(discussing lost chance theory, comparing it to traditional negligence claim which treats causation as "an all-or-nothing proposition"). A lost chance claim requires "[e]xpert testimony . . . to show the defendant's actions probably caused a reduction in the plaintiff's chance of a cure." *Susie v. Family Health Care of Siouxland*, 2018 WL 5848998 *6 (Iowa Ct. App. 2018) (citing *DeBurkarte*). Given Dr. Adams' opinion, Plaintiffs' position that if they fail to prove a medical negligence case, they can ask the jury to still find for them on a lost chance theory is flawed.

A lost chance theory is available in cases where a plaintiff cannot establish causation because the death or injury is attributable to a pre-existing condition—such as cancer. *See Mead v. Adrian*, 670 N.W.2d 174, 186 (Iowa 2003) ("The loss of chance doctrine was created only to allow recovery when traditional negligence principles, particularly causation, preclude recovery . . .") (J. Cady, concurring). The purpose of the doctrine was essentially to relieve a plaintiffs' causation burden when the plaintiff cannot establish causation given the patient's preexisting condition. *See id* at 181-82 (J. Cady, concurring).

As a threshold matter, Plaintiffs' proposed instructions omit the required language that it is when a plaintiff cannot establish *causation* that a plaintiff might be entitled to an alternative lost chance theory. *See* Iowa Uniform Instructions No. 1600.16 (introductory language: "If you find that plaintiff has failed to prove the second proposition of his claim for negligence [the causation element] . . . you must then consider plaintiff's alternative claim for lost chance of survival."); *id.* Note (in the traditional negligence instruction, the jury is instructed "If the plaintiff has failed to prove . . . causation, you will consider plaintiff's alternative claim for lost chance claim is triggered—if at all—when a plaintiff fails to prove causation. This is telling and demonstrates Plaintiffs are attempting to obtain an advantage by submitting alternative claims --and get multiple bites of the apple with the jury—when those alternative claims do not apply.⁶

As indicated above, Plaintiffs' expert does *not* support a lost chance theory. He unequivocally opines that if Dr. Otoadese had performed the second surgery earlier, Mr. McGrew would not have suffered a stroke. This opinion supports a traditional negligence claim—not a lost chance claim.

In addition, the jury would be speculating to determine the percentage of lost chance without the assistance of expert testimony on this issue—and there is no such testimony in this

⁶ Nor do Defendants agree with Plaintiffs' proposed lost chance instruction or theory that if the jury determines a percentage of lost chance greater than 50%, Plaintiffs would be entitled to "all damages" without reduction. *See* Plaintiffs' proposed instruction No. 11B. Plaintiffs are equating a 51% lost chance to a preponderance of the evidence under a traditional negligence claim. Defendants know of no Iowa authority supporting that a lost chance theory—even if the lost chance is over 50%--converts the claim back into a traditional all-or-nothing negligence claim and the right to full damages. Instead, if a jury awards damages under a lost chance theory, it is because the jury did not find traditional negligence and damages are some percent of traditional negligence damages. *See Mead*, 670 N.W.2d at 180 ("The nature of a claim for lost chance of survival is such that *it must be proportionally less* than a recovery for traditional wrongful-death damages for the same decedent in the same case.") (emphasis added); *id.* at 185 (J. Cady, concurring, explaining that lost chance applies even if the lost chance is less than 50% [which obviously implies the lost chance reduction applies when the lost chance is over 50%].

case.⁷ While *Mead* suggests expert evidence is not required as to the percentage, *see* 670 N.W.2d 174 n.5, it is impossible to determine precisely what evidence supported the lost chance theory in *Mead*. To allow a lay jury to determine the percentage of a lost chance completely on their own without guidance from an expert is contrary to voluminous Iowa law that expert testimony is required for complex medical issues. *See* Defendants' trial brief; *see also Miranda v. Said*, 2012 WL 2410945 *9-10 (Iowa Ct. App. 2012) *affirmed* by 836 N.W.2d 8 (Iowa 2013)⁸ (affirming trial court's directed verdict on lost chance theory as jury would be speculating on damages: "the jury had only speculation on which to base any estimation or approximation of the damage claimed").

The alternative lost chance claim should also be excluded because it is not supported by Iowa law. The lost chance theory contemplates that a jury may "fail to find on the evidence that a negligent act was a proximate cause of a patient's death yet believe that *the negligence* deprived the patient of a chance to survive." *Mead*, 670 N.W.2d at 180 (emphasis added). In other words, the alternative claim is based upon the same alleged act of negligence. Here, Plaintiffs' "alternative" lost chance claim is based upon a different alleged negligent act—a delay in returning Mr. McGrew to surgery.

Finally, Plaintiffs did not plead a lost chance theory or give any notice to Defendants prior to submission of their trial pleadings on February 7, 2019 that they were relying on the theory. While *Wendland v. Sparks*, 574 N.W.2d 327, 329 (Iowa 1998) found that a plaintiff was not required to allege a specific loss-of-chance theory in their petition under Iowa's notice-

⁷ Compare DeBurkarte v. Louvar, 393 N.W.2d 131, 135 (Iowa 1986)) (describing plaintiff's expert evidence that to "a reasonable degree of medical certainty the plaintiff's chances of surviving ten years would have been [50 to 80 %]" if the cancer was timely diagnosed but such chances had dropped to 0% by trial).

⁸ The Iowa Supreme Court did not address the Court of Appeals decision on lost chance damages.

pleading rules, the court found the plaintiff *otherwise* made the claim known to the defense. In *Wendland*, the court found the plaintiff "made it clear" it was relying on the lost chance theory during the course of the case, including with an expert witness opinion supporting the theory and in resistance to a motion for summary judgment. *Id.* There was no notice in this case until less than 3 weeks before trial that Plaintiffs would attempt to submit this alternative theory of recovery. That is too late to allow Defendants a fair opportunity to respond and prepare for this claim at trial and allowing the claim will prejudice Defendants.⁹

3. Any testimony or other evidence from treating health care providers that exceeds the proper scope of such testimony or constitutes inadmissible hearsay, including but not limited to after-the-fact non-treatment opinions of Dr. Bekavac and Dr. Halloran.

Plaintiffs designated two physicians as experts under the category of treating physicians neurologist Dr. Ivo Bekavac and radiologist Dr. John Halloran. Plaintiffs have never provided signed expert reports for either physician. Under the Iowa Supreme Court's opinion in *Hansen v*. *Central Iowa Hospital Corp*, 686 N.W.2d 476 (Iowa 2004), evidence from these physicians, if allowed at all, must be limited to opinions formed for the purposes of care and treatment. Further, given these physicians' reports are not entirely treatment records, Defendants do not agree a hearsay exception applies to the records, in whole or in part.

As discussed above, Mr. McGrew had a CT angiogram on August 18, 2014, which was interpreted by radiologist Dr. Cammoun as showing 65% stenosis on the right and 60% stenosis on the left. Dr. Otoadese documented the stenosis at 70% on the right. Mr. McGrew had a carotid endarterectomy on September 2, 2014 and suffered a stroke the next day.

⁹ See, e.g., Klein v. Chicago Central & Pacific Railroad Co., 596 N.W. 2d 58, 61 (Iowa 1999) (purpose of pretrial procedures and discovery rules is to "avoid surprise to litigants and to allow the parties to formulate their positions on as much evidence as is available."); *Trade Professionals Inc. v Shriver*, 661 N.W. 2d 119, 121-22 (Iowa 2003)(party would be prejudiced by the admission of a physician's report, produced approximately seven days *before* a hearing, even though the defendant knew of the existence of the physician).

On September 26, 2014, well after Mr. McGrew had the carotid surgery, Mr. McGrew

saw neurologist Dr. Bekavac for a "second opinion." Exh. 5. Dr. Bekavac writes:

[The CTA] was read by Dr. Cammoun, who felt there was right ICA stenosis around 65%. I did review personally and showed to the patient and his daughter and son and my opinion stenosis of right ICA is approximately 40%. ... Prior to surgery patient was asymptomatic. ... The patient wants to know exactly the reasoning behind surgery whether first surgery and second surgery was indicated.

IMPRESSION:

1. The patient suffered right hemispheric embolic infarct after endarterectomy and occlusion of right internal artery. Initially symptoms possibly related to amaurosis fugax, but 40% of stenosis was not significant to justify endarterectomy in my opinion.

2. In my opinion second endarterectomy probably was not indicated particularly being done after almost eight hours after the new onset of symptoms.

3. I will ask Dr. Halloran, neuroradiologist to review CTA because of discrepancy between my review and Dr. Cammoun review. ...

Exh. 5. Dr. Halloran authored a review of the CT angiogram and opined the right carotid has32% diameter stenosis. Exh. 6.

Neither Dr. Bekavac nor Dr. Halloran stated in their records that Dr. Otoadese or Dr.

Cammoun breached the standard of care, were negligent, or that their negligence caused Mr.

McGrew's stroke. See Exh. 5-6. Neither stated any opinions as to the applicable standard of care

for Dr. Otoadese or Dr. Cammoun. However, Plaintiffs have indicated that "Dr. Bekavac will

testify as to the standard of care [and] causation," including that "The first and therefore the

second endarterectomy were unnecessary and violated the standard of care." Exh. 7 at 3.

Plaintiffs continue that Dr. Bekavac will be "asked to comment on the standard of care in the

evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the

breach of that standard of care; the harm sustained by Bill McGrew; and the cause-and-effect

relationship between the breach of the standard of care and any damages." Id. Almost as an

after-thought, Plaintiffs indicate Dr. Bekavac will also be "asked to comment on the evaluation, care and treatment he has provided to Bill McGrew since he sustained the stroke." *Id.*

As to Dr. Halloran, Plaintiffs describe that "Dr. Cammoun and Dr. Otoadese misread the CTA and violated the applicable standard of care. . . . He will also be asked to comment on the standard of care . . . , any breach of that standard of care, and the cause-and-effect relationship between the breach . . . and any damages." Exh. 7 at 3-4.

Given Plaintiffs' interrogatory answer, it is clear that they intend to attempt to introduce unlimited expert testimony from Drs. Bekavac and Halloran at trial-- testimony on the applicable standard of care, its breach in this case, and causation. This is all without disclosing a written expert report for these physicians. Plaintiffs must not be allowed to do so.

First, even assuming all the information in these physicians' records is otherwise admissible (which it is not), the physicians do *not* offer any opinions on the applicable standard of care, that it has been breached, or that a breach had a causal connection to Mr. McGrew's stroke. They simply do not state these opinions. *See* Exh. 5-6. Dr. Bekavac's statement that the "stenosis was not significant to justify endarterectomy *in my opinion*" (emphasis added) is not sufficient to establish a standard of care or its breach. His "opinion" may not reflect the standard of care. *See also Kush v. Sullivan*, 2013 WL 4437077 *5 (Iowa Ct. App. 2013) (refusing to extrapolate from treating physician's statements that defendant physician's "work fell below a professional norm" or breached the standard of care). Standard of care and breach opinions have never been disclosed from these physicians and are not admissible. *See* Rule 1.517(3).¹⁰

¹⁰ Rule 1.517(3) provides "If a party fails to provide information or identify a witness as required by rule 1.500, 1.503(4), or 1.508(3), the party is not allowed to use that information or witness to supply evidence on a motion, at a hearing, or at a trial, unless the failure was substantially justified or is harmless."

Further, for any treating health care provider for whom Plaintiffs did not provide written expert opinions (including Dr. Bekavac and Dr. Halloran), their testimony is limited under *Hansen v. Central Iowa Hospital Corp*, 686 N.W.2d 476 (Iowa 2004). Only those opinions that the treating health care provider formed in the course of his or her care and treatment, if any, are admissible; those formed in a role analogous to an expert are not. *See id* at 484. ¹¹

In *Hansen*, the Court held causation opinions from a treating physician were admissible notwithstanding the failure to designate the expert or produce an expert report. This is because those opinions were developed during treatment. The Court described the applicable rule for when a treating physician's opinion testimony is admissible without an expert report. The "paramount criterion" is whether the treating physician's opinion "relates to facts and opinions arrived at by a physician in treating a patient or whether it represents expert opinion testimony formulated for purposes of issues in pending or anticipated litigation." 686 N.W.2d at 482 (citation omitted).

The "reason and timeframe in which the underlying facts and opinions were acquired" is critical in determining if the treating physician is focusing less on medical questions and more on legal questions. *Id.* at 483 (citation omitted). "[E]ven treating physicians may come within the parameters of rule 125 [now Rule 1.508] when they begin to assume a role in the litigation analogous to that of a retained expert." *Id.*; *see also Morales v. Miller*, 2012 WL 222527 *8 (Iowa Ct. App. 2011) (testimony was beyond the scope of treatment when physician "had to be

¹¹ While inconsistent with the records of Drs. Bekavac and Halloran, Plaintiffs described a similar rule (without citing *Hansen*) in their resistance brief to Dr. Cammoun's summary judgment motion. See Brief at 4, filed Jan. 8, 2019 ("treating physicians . . can rely on the mental impressions they developed during the treatment process"); *see also id.* at 7 (describing physicians' records as detailing opinions "formulated at the time they provided care and treatment"). Thus, Plaintiffs seem to agree that the treating physicians are limited to opinions formed *during care and treatment*.

briefed on what happened;" plaintiff failed to demonstrate opinions were reached while physician was treating plaintiff).

Here, Dr. Bekavac and Dr. Halloran's records demonstrate--on their face--that they did not formulate their opinions as part of treatment. The opinions as to interpretation of the CT angiogram and indications for surgery were *after* the surgery--a retrospective review of care. Both physicians assumed roles analogous to a retained expert. In addition, standard of care opinions are rarely--if ever--developed in the course of treatment. *See Hansen*, 686 N.W.2d at 482, 484 (treating physicians are not ordinarily required to formulate standard of medical care opinions in the course of treatment). As the Court in *Hansen* noted--in the absence of a disclosed opinion--"an opposing party should ... be able to expect that a treating physician's testimony will not include opinions on reasonable standards of care." *Hansen*, 686 N.W.2d at 482.

Plaintiffs have relied upon Rule 1.500(2) that provides a non-retained expert need not provide a signed written report but that the party need only provide a summary of the witnesses expected testimony. Rule 1.500(2) does not overturn *Hansen*. Recent Iowa appellate cases continue to apply the law set forth in *Hansen* notwithstanding Rule 1.500(2). *See Sherrick v. Obstetrics & Gynecology Specialists, P.C.*, 2018 WL 5846055 *4 (Iowa Ct. App. 2018) (affirming exclusion of treating physician's testimony on "performing ultrasounds" as it "did not relate to the care she provided;" "The treating physician's opinion on the standard of care was expert testimony, and thus improper absent compliance with the required disclosures.") (citing *Hansen*); *Stellmach v. State*, 2017 WL 1735618 *10 (Iowa Ct. App. 2017) ("when a treating physician 'assumes a role in litigation analogous to the role of a retained expert,' supplemental discovery may become obligatory").

Iowa law on the scope of a treating physician's opinions that can be admitted at trial in the absence of an expert report is set forth in *Hansen*. Therefore, Plaintiff's choices as to Dr. Halloran and Dr. Bekavac were: 1) retain them and produce reports so Plaintiffs could rely upon them for non-treatment opinions; or 2) be limited to treatment opinions. Plaintiffs did not retain the physicians or produce reports for them and must be limited to treatment opinions.

Dr. Halloran's report and testimony should be excluded in its entirety as Plaintiffs cannot establish his interpretation of the CT angiogram was reached during care or treatment. Plaintiffs were required to disclose an expert report to use such an opinion and did not. While Dr. Bekavac is a treating physician, Plaintiffs cannot establish that his interpretation of the CT angiogram and opinions as to the two carotid surgeries were formed to treat Mr. McGrew. Dr. Bekavac's report demonstrates, instead, that he had taken on a role analogous to an expert. His opinions must be limited to that which arises from his care and treatment of Mr. McGrew.

In addition, Defendants do not waive hearsay exceptions to the records from Dr. Bekavac and Dr. Halloran.

4. Any evidence regarding, or reference to, the irrelevant and unfairly prejudicial subjects discussed below.

There are numerous collateral and extraneous issues in this case that have consumed time in depositions and discovery. The subjects are not relevant to the medical issues and would be unfairly prejudicial if introduced. They would likely mislead the jury, waste time, and create hostilities or suspicions among jurors against Dr. Otoadese. The subjects should be excluded. *See* Rules 5. 402 and 5. 403. In addition, many of the subjects concern references to other litigation, settlements, and insurance. *See* Rule 5.408, 5.411; *see also* ¶5 below; *State of Iowa v. Henderson*, 696 N.W.2d 5, 10-11 (Iowa 2005) (evidence is unfairly prejudicial when it "appeals to the jury's sympathies, arouses its sense of horror, provokes its instinct to punish, or

triggers other mainsprings of human action that may cause a jury to base its decision on something other than the established propositions in the case'"); *State of Iowa v. Langley*, 2005 WL 1965866 at * 5 (Iowa Ct. App. 2005) (evidence is unfairly prejudicial if it "'would cause the jury to base its decision on something other than the proven facts and applicable law, such as sympathy for one party or a desire to punish a party").

Plaintiff's motion to compel filed against Dr. Cammoun on August 9, 2018, which has now

been withdrawn, explains some context. Plaintiffs sought information to explore the business

relationship between Dr. Cammoun and Dr. Otoadese. Plaintiffs argued:

Dr. Otoadese has testified that he has been prevented from performing cardiac surgery by the local hospital and has been terminated from his former clinic group. A reasonable conclusion from this is that he has been affected financially and therefore may be more willing to consciously or subconsciously consider a more expensive procedure for Mr. McGrew. Dr. Otoadese has described being very close friends with Dr. Cammoun. And it turns out that Dr. Otoadese has a lease relationship with an entity partly owned and principally managed by Dr. Cammoun.

Plaintiffs' motion at ¶9. The motion to compel has been withdrawn, Dr. Cammoun will be

dismissed, and Plaintiffs have not pursued this discovery.

a. That it is "rare," unprecedented, or similarly uncommon for one physician (i.e. Dr. Bekavac or Dr. Halloran) to criticize another.

In depositions and other context, Plaintiffs' counsel characterizes Dr. Bekavac and Dr.

Halloran's records as criticizing another physician and as "rare" -- implying there are worthy of

emphasis and notice. Plaintiffs' characterization should be excluded--particularly given that

much of those "rare" comments should themselves be excluded. See ¶3 above; Rules 5.402,

5.403.

b. Dr. Otoadese's past professional relationship with Cedar Valley Specialists, including references that he was "kicked out," "fired," or "terminated" and it involved the loss of insurance.

There were deposition questions and testimony that Dr. Otoadese was "kicked out," "fired," or terminated from Cedar Valley Medical Specialists. Exh. 4 at 6, 8 (Dep. 14, 22). Dr. Otoadese explained the departure included a lawsuit, settlement out of court, and a decision that he was performing high-risk procedures and not insurable. Exh. 4 at 8 (Dep. 22-23). This event-however characterized--occurred before any care and treatment of Mr. McGrew. Plaintiffs' only medical expert makes no connection between any such events and the care provided. *See* Rules 5, 402, 5,403, 5,408, 5,411

c. The fact that Dr. Otoadese no longer has privileges to do open heart surgery at Allen Hospital and a related lawsuit (including Defense expert Dr. Levett's involvement).

There was deposition testimony that Dr. Otoadese no longer does open heart surgery at Allen. Plaintiffs' counsel characterized it as under the "insistence of the hospital." Dr. Otoadese explained that it was "political," "even resulted in a lawsuit and was settled out of court," was not "straightforward," and his ceasing to do open heart surgery was "negotiated." Exh. 4 at 7 (Dep. 16-18). Plaintiffs also deposed Defense expert Dr. Levett on this subject as Dr. Levett served as an expert for Allen hospital. The discussion with Dr. Levett included that the dispute involved cardiac surgery privileges. Dr. Cammoun also resigned privileges from Allen hospital.

This case does not involve heart surgery or hospital privileges. Plaintiffs' only retained expert offers no opinion about Dr. Otoadese's qualifications or privileges. This subject is not relevant. It would introduce complicated and prejudicial collateral issues into the case that would only detract from the medical issues and likely confuse the jury. If introduced, it would require response time from the defense. The subject involves matters of other litigation and likely would require explanation of peer review--both subjects that should be excluded on their own merit. *See* Rules 5. 402, 5.403, 5. 408; ¶ 5, 6.

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d. That Dr. Cammoun's business entity leases space to Dr. Otoadese.

Dr. Cammoun explained that his entity, ADI, leases space to Dr. Otoadese for him to do ultrasounds. This has no relevance whatsoever, particularly now that Dr. Cammoun will be dismissed. *See also* ¶4(e) below; Rules 5. 402, 5.403.

e. Suggestions that there was a financial motive behind Dr. Otoadese's care decisions.

As explained above, Plaintiffs counsel has attempted to create or imply a financial motive to Dr. Otoadese. After discussion of Dr. Otoadese's cessation of open heart surgery, it was implied Dr. Otoadese lost much of his practice--somehow suggesting that recommending surgery to Mr. McGrew was financially motivated. Exh. 4 at 7-8 (Dep. 19-22). When asked about an ultrasound on Mr. McGrew, Dr. Otoadese explained that he did not repeat the test as there would be no reimbursement--but since he was ordering a CT angiogram anyway, a repeat ultrasound "did not matter." Exh. 4 at 19-20 (Dep. 67-68). In ordering the CT angiogram, Dr. Otoadese testified he prefers studies done at ADI ("Advanced Diagnostic Imaging"), which is Dr. Cammoun's business, because it a local radiologist. Exh. 4 at 22 (Dep. 76-79). There was also evidence that Plaintiffs were charged a "no show" fee at Dr. Otoadese's office--unknown to Dr. Otoadese. Exh. 4 at 17 (Dep. 56-58).

These discrete pieces of evidence may be strung together by Plaintiffs to attempt to vilify Dr. Otoadese. But any speculative and fabricated theory of a financial motive is not relevant to the medical care. Plaintiffs' expert does not suggest otherwise. Further, the theories and speculations would be highly prejudicial to Defendants, creating the distinct possibility of a jury verdict on an improper basis. *See* Rules 5. 402, 5.403.

f. The fact that the entire medical record was not produced to Plaintiffs initially.

In Dr. Otoadese's deposition, Plaintiffs asked why an August 18, 2014 initial consult was not produced initially by his office-- which was unknown to Dr. Otoadese. Exh. 4 at 18 (Dep. 61-63). *See* Rules 5. 402, 5.403.

g. Suggestions about personal relationships among physicians, including Dr. Otoadese, prior Defendant Dr. Cammoun, Dr. Bekavac, and Dr. Halloran.

Dr. Otoadese testified about friendships, professional relationships, and socializing among the physicians --and that it has changed over time. Exh. 4 at 8-9 (Dep. 23-26). Plaintiffs counsel asked Dr. Otoadese to essentially speculate why Dr. Bekavac and Halloran would write the reports they did and if Dr. Otoadese had confronted them. Exh. 4 at 29 (Dep. 104-106).

Again, Plaintiffs' medical expert provides no basis for this subject to be relevant. It is not. Its only use would be to create hostility or suspicions. Rules 5. 402, 5. 403.

h. That Dr. Otoadese took the board certification test two times to pass.

Dr. Otoadese is board certified and testified he took the exam two times the first time. Exh. 4 at 10 (Dep. 28). The number of times a physician takes a board certification exam many years before the care and treatment involved in a case is not relevant. If relevant at all, its probative value is outweighed by the danger of unfair prejudice. Plaintiffs' expert offers no opinion that Dr. Otoadese is not qualified or sufficiently trained or experienced. Rule 5. 402, 5.403.

5. Any reference to, or evidence concerning, other patients, claims, patient complications or adverse outcomes, or lawsuits involving Dr. Otoadese.

As explained above, there have been other suits mentioned in discovery, including with Cedar Valley Specialists and Allen Hospital. These and any other medical malpractice action should be excluded. Such evidence of, or even reference to, other suits, claims, and patient complications is inadmissible under Rule 5.402; should be excluded as prejudicial and resulting

in a confusion of issues under Rule 5.403; and should be excluded as "other wrongs or acts" evidence under Rule 5.404(b).

Even if evidence about other patients or lawsuits was relevant (which it is not), it should be excluded under Rule of Evidence 5.403. The admission of such evidence would result in waste of time on collateral issues, create undue delay, and mislead the jury. Furthermore, any possible probative value of this evidence is substantially outweighed by the unfair prejudice to Defendants.

Other courts have held that, in the context of medical malpractice, other incidents and other medical malpractice suits, are not relevant, are highly prejudicial, and should not be admitted. *See Lai v. Sagle*, 818 A.2d 237, 247-48 (Ct. App. Md. 2003).

The fact of prior litigation has little, if any, relevance to whether [the physician] violated the applicable standard of care in the immediate case. The admission of evidence of prior suits, instead of aiding the fact finder in its quest, tends to excite its prejudice and mislead it. . . .[We] cannot conceive of a more damaging event, in a medical malpractice trial, than disclosure to the jury in opening argument that the defendant doctor had previously been sued multiple times for malpractice.

818 A.2d at 247 (finding trial court abused its discretion in not granting a mistrial for improper opening argument); *id.* at 246 (also finding such evidence "is not probative of a physician's professional qualifications, or lack thereof"); *see also Cerniglia v. French*, 816 So.2d 319, 324-35 (La. Ct. App. 2002) (finding trial court erred in allowing testimony of physician's former patients who suffered similar complications as plaintiff as testimony was not probative on negligence or physician's knowledge and skill and evidence was too prejudicial even if probative as it allowed jury to make improper inferences).

Such evidence is also inadmissible under Iowa Rule of Evidence 5.404, under which a party typically cannot introduce character evidence or evidence of "other wrongs or acts" to prove that a person acted in conformity therewith.

6. Any reference to, or evidence concerning, peer review; credentialing; privileging; morbidity and mortality monitoring; or other investigations, evaluations, or charges (if any) involving Defendant, the Iowa Board of Medical Examiners, or another entity or individual.

To the extent Plaintiffs attempt to elicit testimony, make references to, or introduce

documents that pertain in any way to peer review or other evaluative activities (whether

pertaining to this case or to Defendant in general), such evidence is not relevant to any claim.

Evaluative or investigative type evidence, or reference to such activity, would also be highly

prejudicial to Defendants-carrying a negative connotation. The evidence is inadmissible under

Rules 5.402 and 5.403, statutory and regulatory peer review privileges, and Iowa case law. See

Iowa Code §147.135(2); Iowa Code §135.40 and .42.

7. Any testimony regarding, or references to, alleged out-of-court statements by health care providers (other than Dr. Otoadese).

The depositions of Plaintiffs revealed many out-of-court statements by health care providers (other than Dr. Otoadese). Such statements are inadmissible hearsay. See Rule 5.802.¹²

They are also inadmissible under Rule 5. 403. Plaintiffs have a medical expert to provide testimony on the medical issues in this case. The jury is not to make a determination of medical

¹²Such statements would not be admissible under 5.803(4) "Statement for purposes of medical diagnosis or treatment." That exception applies to statement made by patients *to* their health care providers—not the other way around. The rationale for the rule is that "a statement made in the course of procuring medical services, where the declarant knows that a false statement may cause misdiagnosis or mistreatment, carries special guarantees of credibility." *State v. Mann*, 512 N.W.2d 528, 535-36 (Iowa 1994) (citation omitted); Fed. R. Evid. 803(4) Advisory Committee Note (exception applies to statements that the *patient* makes to health care providers, not statements made by health care providers); *Carbonnell v. Bluhm*, 318 N.W.2d 659, 664 (Mich. Ct. App. 1982) ("The rule in MRE 803(4) does not apply to statements by the doctor regarding the patient's physical condition.").

negligence or causation based upon a layperson's understanding and then repetition of what a health care provider said. It would be highly prejudicial and inconsistent with expert rules applicable to medical malpractice cases for Plaintiffs to introduce Plaintiffs' restatement of what they understood on medical issues. Upon hearing such hearsay, the jury could find against Defendants—not because there was evidence of a breach of the applicable standard of care—but because of this hearsay.

Without limiting the scope of this limine request, Defendants identify the following hearsay statements that should be excluded:

- a. Mr. McGrew testified three unidentified cardiologists (two from Mayo and one from Waterloo) told him he didn't need surgery and could be cured by aspirin.
 Exh. 2 at 7 (Dep. 27).
- b. Mrs. McGrew testified Dr. Hassani told her there was a two hour window after the stroke for return to surgery. Exh. 3 at 10 (Dep 39: 19-24).
- c. Elaine McGrew testified that Dr. Halloran told her daughter [double hearsay] that the blockage was not sufficient for surgery. Exh. 3 at 19-20 (Dep. 76:22-77:4).
- d. Elaine McGrew testified that Dr. Bekavac told her that surgery was unnecessary.
 Exh. 3 at 19 (Dep 74:1-12)..

The jury should hear directly from experts or testifying treating health care providers on these subjects, if at all—not lay witnesses who attempt to recall what they remember and then repeat it as best as possible.

8. Any evidence regarding, or references to, future medical expenses (or life care expenses) other than those to be paid by Plaintiffs themselves.

As set forth in Defendants' trial brief, Iowa Code §147.136 applies in this case. That statute provides that damages for economic losses in a medical malpractice case such as this one

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are not recoverable if paid or to be paid by insurance, a governmental program, or any other source --other than Plaintiffs or Iowa's Medicaid program under Iowa Code Chp. 249A. Thus, under this statute, a medical malpractice plaintiff typically recovers their only out-of-pocket medical expenses.

In a January 23, 2019 supplemental interrogatory answer, Plaintiffs have indicated they have reached a settlement with United Healthcare Services, Inc "with regard to any lien or subrogation interests it may have arising from this lawsuit." (Plaintiffs previously indicated Medicaid "has indicated that no payments were made."). Accordingly, any past and future medical expenses paid or to be paid by Plaintiffs' health plan (United Healthcare Services, Inc.) are not recoverable. Even assuming that the past and future lien and subrogation interests of United Healthcare Services were enforceable given Iowa Code §147.136, those interests have been satisfied. As such, Plaintiffs' recovery under Iowa law is limited to their future out-of-pocket medical expenses. Evidence about other future medical expenses is not relevant and would be unfairly prejudicial. *See* Rule 5.402, 5.403.

9. Any reference to liability insurance coverage.

It is "generally improper for the subject of liability insurance to be raised in any way before the jury." *Strain v. Heinssen*, 434 N.W.2d 640, 642 (Iowa 1989)(discussing Rule of Evid. 5.411)(citing *Evans v. Howard R. Green Co.*, 231 N.W.2d 907, 914 (Iowa 1975)). The rationale underlying Rule 5.411 is that "evidence of insurance is rarely probative and frequently prejudicial." *Id.* at 642. Such evidence is inadmissible under Rules 5.402, 5.403, and 5.411. See *Strain*, 434 N.W.2d at 643 (refusing to apply exception in Rule 5.411 to allow evidence that an expert was paid by an insurance company for testimony). The Iowa Supreme Court in *Strain*

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acknowledged the significant prejudicial impact of insurance evidence and affirmed its exclusion when offered to suggest an expert was biased. *Id*.

10. Any reference to, or evidence concerning, punitive damages, punishing Defendants, or "sending a message" to Defendants or medical providers in general.

Plaintiffs do not have a claim for punitive damages. Any mention of punishing or that the jury should "send a message" to Defendant is irrelevant and would be highly prejudicial. *See* Rules 5.402; 5.403; *Nishihama v. City and County of San Francisco*, 112 Cal. Rptr. 2d 861, 865 (Ct. App. 1st Dist. Div.1 2001) ("Any suggestion that the jury should 'send a message' by inflating its award of damages, however, would be improper . . ." where punitive damages are not submitted).

11. Any reference to the relative size, earning powers, or economic or financial condition of the parties or their law firms, including that Defendants may have more lawyers working on this matter than Plaintiffs.

Any testimony, argument, or evidence that compares the respective earning powers or

financial or economic conditions of Plaintiffs and Defendants should be excluded. Plaintiffs should not be permitted to characterize themselves directly or indirectly as the underdog in this case or in any way, imply that the Defendants have the ability to spend more money or devote more resources to the case.¹³

¹³ See Burke v. Reiter, 42 N.W.2d 907, 912 (Iowa 1950)(affirming grant of new trial for defendant due in part to plaintiff counsel's improper reference to the comparative wealth of parties; "[C]omparison of respective earning powers or financial or economic conditions is entirely improper"); see also Rosenberger Enterprises, Inc. v. Insurance Serv. Corp. of Iowa, 541 N.W.2d 904, 907 (Iowa 1995) ("When determining liability it is improper for the jury to consider the relative wealth of the parties."); Hackaday v. Brackelsburg, 85 N.W.2d 514, 518 (Iowa 1957) ("Of course we do not approve any reference in argument to the worth or poverty of a litigant"). "It is prejudicial for a plaintiff to improperly introduce the question of wealth into the trial of a case involving only compensatory damages." Burke v. Deere & Co., 6 F.3d 497, 513 (8th Cir. 1993) (Iowa law), cert. denied, 114 S.Ct. 1063 (citing Trapalis v. Gershun, 145 N.W. 2d 591, 596 (Iowa 1966) (noting a large compensatory award can "raise the question whether the jury was improperly influenced" by the evidence of the defendant's wealth).

Nor should Plaintiffs be allowed to refer to the number of lawyers in the undersigns' firm or working on this matter. This topic is irrelevant, prejudicial, and inadmissible under Rules 5.402 and 5.403.

12. Any reference to settlement offers, or lack thereof, and negotiations, including the settlement by Dr. Cammoun.

Any such evidence is inadmissible pursuant to Rule 5.408.

CONCLUSION

For the reasons set forth above, Defendants respectfully request that the Court grant their

Motion in Limine.

JENNIFER E. RINDEN AT0006606

CERTIFIC The undersigned he this document was s for each party to the	erved upon cou	hat a copy of nsel of record
R.C.P. 1.442(b) on:	Feb. 1	2 20 19
By: Overnight Couri Hand Delivered Cervised Nail Signature		E mailed E filed

cc: Martin A. Diaz, Esq. 1570 Shady Ct NW Swisher, IA 52338

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Honorable George Stigler Black Hawk County Courthouse 316 East 5th Street P.O. Box 9500 Waterloo, IA 50704-9500 E-mail: <u>George.stigler@iowacourts.gov</u>

SHUTTLEWORTH & INGERSOLL, P.C. 500 U.S. Bank Bldg., P.O. Box 2107 Cedar Rapids, IA 52406 PHONE: (319) 365-9461 FAX: (319) 365-8443 e-mail: jer@shuttleworthlaw.com ATTORNEYS FOR EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.

EROMOSELE OTOADESE, M.D. 5-8-18

1	IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY
2	
3	WILLIAM MCGREW and) ELAINE MCGREW,)) NO. LACV130355
4	Plaintiffs,)
5	vs.) Videotaped
6) Deposition of EROMOSELE OTOADESE,)
7	M.D.; NORTHERN IOWÁ) EROMOSELE OTOADESE, CARDIOVASCULAR AND) M.D.
8	THORACIC SURGERY) CLINIC, P.D., and) DRISS CAMMOUN, M.D.,)
9	Defendants.
10	Defendants.)
11	
12	
13	Videotaped Deposition of EROMOSELE
14	OTOADESE, M.D., taken before Julie M. Kluber,
15	Certified Shorthand Reporter, commencing at
16	9:32 a.m., March 8, 2018, at 515 Main Street,
17	Suite E, Cedar Falls, Iowa.
18	
19	
20	
21	
22	
23	Julie M. Kluber, CSR, RMR 3515 Lochwood Drive NE
24	Cedar Rapids, IA 52402 319-286-1717
25	1-866-412-4766

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EROMOSELE OTOADESE, M.D. 5-8-18

	1	APP	EARANCES
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	7	Defendants Otoadese	JENNIFER E. RINDEN
	8	and Northern Iowa Cardiovascular and	VINCENT S. GEIS Attorneys at Law 115 Third Street SE, Suite 500
	9	Thoracic Surgery Clinic by:	P. O. Box 2107
1	10		Cedar Rapids, IA 52406-2107
-	11	Defendant Cammoun by:	GEORGE L. WEILEIN Attorney at Law 515 Main Street, Suite E
	12		P. O. Box 724
	13		Cedar Falls, IA 50613
	14	Videographer:	Josh Goding
	15		
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EROMOSELE OTOADESE, M.D. 5-8-18

INDEX OF EXAMINATION 1 2 Page Lawyer 4, 121 Mr. Diaz 3 119, 129 Ms. Rinden 4 5 6 7 8 INDEX OF EXHIBITS 9 ID'd Number **Exhibit** 10 Curriculum Vitae of Eromosele 11 1 4 Otoadese, M.D. 12 66 5 8-6-14 carotid study 13 6 8-18-14 CT angiogram of neck with contrast report 79 14 102 15 7 8-28-14 office visit note 8 Calendar page September 2014 34 16 29 9-2-14 Procedure Report 9 17 10-3-14 bilateral carotid 17 18 arteries duplex ultrasound 51 19 report 51 10-3-14 office visit note 18 20 22 11-16-16 statement from NIA 21 Cardiovascular Thoracic to 56 William McGrew 22 61 23 8-28-14 consultation report 23 24 Dr. Otoadese's hand-drawn 24 85 diagram of carotid artery 25

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EROMOSELE OTOADESE, M.D. 5-8-18 6 4 A. I did - Yeah, I did - I did graduate work in PROCEEDINGS 1 1 biochemistry. 2 THE VIDEOGRAPHER: Good morning. We're on 2 3 the record at 9:32 a.m., March 8, 2018, at the 3 Q. So you were a student, then, the entire time law offices of Weilein and Boller, P.C., in 4 or ---4 A. Yes. 5 5 Cedar Falls, Iowa. Q. - only part of that time? EROMOSELE OTOADESE, M.D., 6 6 7 called as a witness, having been first duly 7 A. No. I was a student the whole time. sworn, testified as follows: 8 Q. So when you came to the United States in 1971, 8 did you come to go to college or -- or was it 9 DIRECT EXAMINATION 9 high school or what was that? 10 BY MR. DIAZ: 10 Q. Doctor, could you please introduce yourself by A. I finished high school in Costa Mesa in 11 11 12 California, then went to college. providing us with your full name. 12 Q. Okay. So pretty much from when you came to the 13 A. Anthony Eromosele Otoadese. 13 Q. All right. And I understand you like to go by 14 U.S. in 1971 up until 1987, when you start 14 15 medical school, you are -- you're a student. Dr. Tony? 15 16 Correct? 16 A. Yes. 17 A. Yes. Graduate student, yes. Q. Okay. Doctor, in front of you is a document 17 marked Exhibit 1, which is -- my understanding 18 Q. Right. Both high school, undergrad, graduate, 18 is this is your c.v. that was provided to us. 19 and now you're going to go to medical school. 19 A. Medical school, yes. 20 Can you look at it and let me know if this is 20 Q. Okay. And then you're in medical school up up to date. 21 21 22 until 1987, and then from there you do your 22 A. Yes, it is. 23 residency, your fellowship - I'm sorry, your Q. Okay. My understanding is you were born in 23 24 internship, your residency, and then 24 Nigeria? 25 A. Yes. 25 fellowships that take you all the way up to 5 7 1996. Correct? Q. And what year did you come to the 1 1 A. Yes. Correct. 2 2 United States? A. 1971. Q. So essentially you're a student from 1971 up 3 3 4 until 1996. Q. And for what purpose did you come to the U.S.? 4 A. Yes. 5 A. To study. 5 Q. And what did you want to study when you first Q. Okay. And the way you get to Iowa is you do 6 6 7 your fellowship at the University of Iowa came in 1971? 7 8 Hospitals and Clinics. A. I wanted to go to college to get an education 8 A. Yes, I did. first. I wanted to do sociology in college, 9 9 Q. Okay. Now, have you done any additional but I ended up majoring in chemistry. 10 10 Q. Okay. My understanding is you went to the 11 education other than what we see up through 11 University of California at Santa Cruz and you 12 1996? 12 13 A. As far as - you mean college education or -got a degree in 1978. 13 or specialty training? I don't understand what A. Yes. 14 14 Q. And a chemistry major? 15 the question is. 15 Q. Sure. So your c.v. takes us all the way up to 16 A. Chemistry, yes. 16 17 1996, and my understanding is that you start Q. Okay. And then the next thing that I have on 17 working, then, in Waterloo in around 1996? your c.v. is that you then went to medical 18 18 19 A. Yes. I finished - This is the only job I 19 school at the State University of New York 20 ever had. I finished, I took a job here, and Downstate in Brooklyn and got your medical 20 I've been here since then. 21 degree in 1987. 21 Q. Okay. And what I'm interested in knowing is in 22 A. Yes. 22 23 addition to what you already have on your c.v., Q. Okay. Your c.v. doesn't tell us what you did 23 24 is there any additional medical education or between 1978 and 1987. Can you tell us what 24 25 training that you've had since 1996? 25 you did?

EROMOSELE OTOADESE, M.D. 5-8-18 10 8 example, and you say, "I want to do open A. Over the years, yes. I -- You know, I got 1 1 surgeries like I've been trained to do and I into interventional vascular surgery and I took 2 2 3 want to do endovascular work like I've been training in this. 3 trained to do," do you have to show the Q. So what's interventional vascular work? What 4 4 hospitals anything there in terms of showing 5 is that? 5 them that you've actually trained in any of A. Interventional endovascular procedures, using 6 6 balloons and stents to supplement, to 7 this? 7 A. Well, that's not relevant for me because I've complement the open surgeries that I do. 8 8 never gone to look for a job somewhere. I've Q. Okay. So up through 1996 in terms of your 9 9 10 never been faced by that. training, was your training limited to open 10 Q. Okay. Well, have you done endovascular work in 11 type procedures? 11 the hospital, let's say -- let's say -- Let's 12 A. Open, yes. 12 talk about your hospital work here. Q. And did you start learning endovascular work? 13 13 A. After that. 14 A. Yeah. 14 Q. My understanding is that practically all of Q. After that. 15 15 your hospital work is at Allen Memorial 16 A. Right. 16 Hospital. Is that right? 17 Q. Okay. And do you list that anywhere on your 17 A. Yes, yes. 18 c.v.? 18 Q. I think at one time you said it was 99 percent A. No, you don't - I don't need to. Just --19 19 It's just not -- I didn't get diplomas or 20 of your work? 20 A. Yeah. I would say that, yeah. anything from it, so --21 21 Q. And I'm not going to hold you to exact Q. Or certificates? 22 22 23 percent ---A. No certificates, no. 23 Q. Well, when you --24 A. That's right. 24 A. They're meetings. You go to meetings. Some of 25 Q. -- but your point is that almost all of your 25 11 g work is there? them a week, some of them two weeks. Hands-on 1 1 A. Yes. experience and things, yeah. 2 2 3 MS. RINDEN: You guys can't talk at the Q. Okay. And ---З same time. Let him finish. A. I did that. 4 4 Q. Have you done, then, endovascular work since 5 THE WITNESS: Okay, sorry. 5 MS. RINDEN: It's all right. when? When was the first time you started 6 6 Q. So when it comes to Allen Memorial Hospital, do 7 doing endovascular work? 7 you share with them, then, this information 8 A. In the '90s maybe. '99, 2000, I don't 8 that says, "I've been trained in endovascular 9 recollect but around there. 9 work"? Did you share that information with Q. Okay. So where did you get the training 10 10 them? necessary that allows you to do that type of 11 11 A. Yes. When I go to training, I come back. If I work; that is, the endovascular work? 12 12 want to do a new procedure, they require that A. All over the country. University of Michigan, 13 13 you go get trained. I come back and I tell Arizona Heart Institute, University of Missouri 14 14 15 them that, yes, I - I just got back from in Columbus, and various meetings, you know. 15 Arizona Heart Institute and I went to learn 16 Texas Heart Institute. 16 endovascular repair of aneurysms, you know, and 17 Q. But none of that is on your c.v. Correct? 17 it's something new that the hospital doesn't 18 18 A. That's correct, yes. do. I'm interested in it, I go learn it, I 19 Q. Okay. 19 come back and I do it. A. There is not -- I usually don't list those 20 20 because, again, I didn't get degrees from 21 Q. Okay. And my understanding that once you 21 22 finished your training at University Hospitals there. I just listed places where I got 22 and went into private practice, you came to 23 23 degrees. 24 Waterloo and you - you were with one Q. Okay. And then in terms of when you go to 24 apply for privileges at a hospital, for 25 particular -- I want to call it a clinic. I 25

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		EROMOSELE OTOAD	ESE, N	1.D.	5-8-18
		12	1	Δ	Um-hmm. Yes.
1		don't know what you would what you called it	2		And then my understanding is in 2013, you open
2		back then, but there were it was you and a	2	ц.	up Northern Iowa Cardiovascular and Thoracic
3		couple of other colleagues that ran a a	4		Surgery Clinic, P.C.
4		clinic. What was the name of that clinic?		٨	Yes, I did.
5	Α.	I'm trying to remember. Cardiac Surgery	5		Okay. And actually, the records show that you
6		Associates or something like that, yes.	6	Q.	formally created the company in November of
7	Q.	Right. And then at some point Cardiac Surgery	7		2012. Is that is that about right?
8		Associates merges with Cedar Valley Medical	8	•	
9		Specialists, Professional Corporation.	9		Yes, yes. In anticipation that you're going to start
10		Correct?	10	Q.	January 1 of 2013. Correct?
11	Α.	Right. It wasn't a merger, but but we we	11	٨	I don't remember the dates. Yes.
12		joined them. We we were asked to join them	12		And it's true, isn't it, that you were
13		because the cardiologists at the hospital were	13	Q.	
14		part of Cedar Valley. We were independent and	14		terminated from Cedar Valley Medical Specialists? I think you described it as they
15		Dr. John Wiggins, he was the senior partner.	15		
16		He had hired me. He didn't want to join Cedar	16		kicked you out. Is that correct?
17		Valley, he wanted to be independent, but the	17		Correct, yes.
18		cardiologists who we work very closely with	18	Q.	Okay. Now, I want to talk about the kind of
19		were part of Cedar Valley, so the hospital	19		work that you've done since you started in
20		administrator said it's it's easier and	20		started in private practice in roughly 1996.
21		works better if when the surgeons and the	21		We talked about you doing open procedures.
22		cardiologists are in the same group. So we	22		Yes.
23		were made to join them politically, and that's	23		And endovascular work.
24		one reason John left.	24		Yes.
25	Q	Okay. And then my understanding is you were at	25	Q.	. So I want to understand the difference. So 15
		13			when you talk about open procedures, what are
1		Cedar Valley Medical Specialists from 1999	1		
2		until 2012 through 2012.	2	•	we talking about there? . Open surgery where you you open up. An
3		Yes.	3	А.	
4	Q	Okay And as part of that are you considered			exemple would be an abdominal actic aneurysm
5		Okay. And as part of that, are you considered	4		example would be an abdominal aortic aneurysm.
6		a partner? A shareholder? A member? What	5		For a long time before the endovascular
7		a partner? A shareholder? A member? What was what was the relationship within that	5 6		For a long time before the endovascular methods, you it was done open method where
		a partner? A shareholder? A member? What was what was the relationship within that organization?	5 6 7		For a long time before the endovascular methods, you it was done open method where you open up the abdominal wall, got in the
8	A	a partner? A shareholder? A member? What was what was the relationship within that organization? Cedar Valley Medical Specialists is a group of	5 6 7 8		For a long time before the endovascular methods, you — it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced
8 9	A	a partner? A shareholder? A member? What was what was the relationship within that organization? Cedar Valley Medical Specialists is a group of specialists. I think we were 23 specialties	5 6 7 8 9		For a long time before the endovascular methods, you — it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced it with a graft. But with the endovascular
	A	a partner? A shareholder? A member? What was what was the relationship within that organization? Cedar Valley Medical Specialists is a group of specialists. I think we were 23 specialties and 55 surgeons, and if I remember correctly,	5 6 7 8 9 10		For a long time before the endovascular methods, you it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced it with a graft. But with the endovascular procedure, we can less invasive so that you're
9 10 11	А	a partner? A shareholder? A member? What was what was the relationship within that organization? Cedar Valley Medical Specialists is a group of specialists. I think we were 23 specialties and 55 surgeons, and if I remember correctly, when you first joined you're not a shareholder	5 6 7 8 9 10 11		For a long time before the endovascular methods, you it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced it with a graft. But with the endovascular procedure, we can less invasive so that you're able to do them without opening the abdomen.
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25 Q. Correct?

heart work?

	EROMOSELE OTOAD	ESE, N	1.D.	5-8-18
1	A. Heart surgery. Valve replacement, coronary	1		him – you finish your answer and then let him
2	artery bypass grafting, aneurysm resection.	2		finish, Marty.
2	You open the chest.	3	А	If you insist that I go into it, it was a
	Q. Okay. Now, if you If somebody were to come	4	73.	political thing, and and I wasn't I
4	to you today and say, "I want to do open	5		wasn't in agreement with with with things
5	heart" "I want you to do an open heart	6		and I sued the hospital, and that resulted in a
6	•			lot other things. All I can tell you is that I
7	surgery," would you be able to do that on them?	7		am still in good standing in the hospital.
8	A. I could but I don't do them anymore. I stopped	8		do all my surgeries there. I I mean I'm
9	doing open heart in 2009.	9		
10	Q. I think you've testified in the past that you	10		still on the on the hospital staff in good
11	stopped doing open heart surgeries in 2008 and	11	~	standing.
12	that you	12	Q.	Okay. So just to summarize, there was some
13	A. Okay.	13		sort of disagreement between you and the
14	Q voluntarily surrendered your privileges to	14		hospital that related to doing open heart
15	do open heart surgeries.	15		surgeries. Your viewpoint is that there was a
16	A. Yes, I did.	16		political decision. Correct?
17	Q. Okay. And that my understanding is that that	17		Correct.
18	was at the insistence of the hospital. Is that	18	Q.	It ended up in you filing a lawsuit with some
19	true?	19		kind of a settlement that's confidential.
20	A. No.	20		Correct?
21	Q. That's not true?	21		Correct.
22	A. No.	22	Q.	Okay. All right. The fact is that you've not
23	Q. All right. So it was your desire all along to	23		done open heart surgeries, then, since roughly
24	just stop doing open heart surgeries in 2008,	24		2008, 2009. Is that true?
25	2009?	25	Α.	2009, yes.
	17			19
1	MS. RINDEN: Well, hold on. I'm going to	1	Q.	. Okay. Now, my understanding from looking at
1 2	MS. RINDEN: Well, hold on. I'm going to object to the form. Argumentative.	1 2	Q.	Okay. Now, my understanding from looking at things you've said in the past that you were
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		EROMOSELE OTOAD	ESE, N	1.D.	5-8-18
1	0	Okay. And then 10 to 20 percent would be	1	A.	Because we were doing them about 300 300
2	- .	noncardiac thoracic.	2		two-eighty to 300 hearts, open hearts a year.
3	А.	Yes.	3	Q.	They just take longer.
4		Meaning what?	4		Yes.
5		Lungs, esophagus, you know, anything in the	5	Q.	And so for that reason, 50 percent, 60 percent
6		chest other than heart.	6		of your time may be a more appropriate way
7	Q.	Okay. In this timeframe before you stopped	7		rather than saying 50, 60 percent of your
8		doing the open heart surgeries, when you did	8		surgeries.
9		vascular work, what percentage of your vascular	9	Α.	Well, yeah. Yes, I agree with that.
10		work was open and what percentage was	10	Q.	Okay. All right. Now, you have testified in
11		endovascular?	11		the past that despite your being fired from
12	Α.	I can't I can't guess. I can't I can't	12		Cedar Valley Medical Specialists in 2012 that
13		guess. I think most of it was open. But I	13		you maintained, quote, "a good working
14		can't give you percentage.	14		relationship with those folks."
15	Q.	In reading what you've testified in the past	15	Α.	Yes.
16		about, I got the impression that you were far	16	Q.	Okay.
17		more comfortable doing open procedures than you	17	Α.	Let let me back up a little. I don't know
18		were doing endovascular. Is that a fair	18		about the fired. If you if you want to know
19		statement?	19		details of why I left Cedar Valley, I said they
20	Α.	In the – in the beginning, yes, because the	20		kicked me out. Is – There was a lawsuit. A
21		open was what I was trained doing.	21		patient developed a foot drop from vein
22	Q.	Right.	22		surgery, which I'd never seen. I do a lot of
23	Α.	But I'd say learned more endovascular and got	23		vein surgery, and there was a lawsuit and they
24		better in it, and I'm just as comfortable doing	24		sued the lawsuit was settled out of court,
25		endovascular now.	25		and the Cedar Valley organization decided that
			1		0.2
		21			23
1	Q.	Okay. All right. And so that we get an idea	1		I was doing high-risk procedures and I was not
2	Q.	Okay. All right. And so that we get an idea of how many surgeries you would do, all types,	2		I was doing high-risk procedures and I was not insurable, and that was what led to that.
2 3	Q.	Okay. All right. And so that we get an idea of how many surgeries you would do, all types, in this timeframe before your disagreement with	2 3		I was doing high-risk procedures and I was not insurable, and that was what led to that. Because I was not insurable, I could not be
2 3 4	Q.	Okay. All right. And so that we get an idea of how many surgeries you would do, all types, in this timeframe before your disagreement with Allen Hospital, how many surgeries do you think	2 3 4		I was doing high-risk procedures and I was not insurable, and that was what led to that. Because I was not insurable, I could not be part of Cedar Valley, so I left. With the
2 3 4 5	Q.	Okay. All right. And so that we get an idea of how many surgeries you would do, all types, in this timeframe before your disagreement with Allen Hospital, how many surgeries do you think you would do in a year's time?	2 3 4 5		I was doing high-risk procedures and I was not insurable, and that was what led to that. Because I was not insurable, I could not be part of Cedar Valley, so I left. With the membership, I left in good terms. I I got
2 3 4 5 6	Q.	Okay. All right. And so that we get an idea of how many surgeries you would do, all types, in this timeframe before your disagreement with Allen Hospital, how many surgeries do you think you would do in a year's time? MS. RINDEN: I'm going to object to the	2 3 4 5 6		I was doing high-risk procedures and I was not insurable, and that was what led to that. Because I was not insurable, I could not be part of Cedar Valley, so I left. With the membership, I left in good terms. I I got my own insurance, started my own corporation,
2 3 4 5 6 7		Okay. All right. And so that we get an idea of how many surgeries you would do, all types, in this timeframe before your disagreement with Allen Hospital, how many surgeries do you think you would do in a year's time? MS. RINDEN: I'm going to object to the form. You can go ahead and answer, Doctor.	2 3 4 5 6 7	0	I was doing high-risk procedures and I was not insurable, and that was what led to that. Because I was not insurable, I could not be part of Cedar Valley, so I left. With the membership, I left in good terms. I I got my own insurance, started my own corporation, and I'm still here.
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2 3 4 5 6 7 8 9		Okay. All right. And so that we get an idea of how many surgeries you would do, all types, in this timeframe before your disagreement with Allen Hospital, how many surgeries do you think you would do in a year's time? MS. RINDEN: I'm going to object to the form. You can go ahead and answer, Doctor. Yes. I would say until again, I can't put numbers in it, but all I can tell you that I	2 3 4 5 6 7 8 9		I was doing high-risk procedures and I was not insurable, and that was what led to that. Because I was not insurable, I could not be part of Cedar Valley, so I left. With the membership, I left in good terms. I I got my own insurance, started my own corporation, and I'm still here. Okay. But and I don't want to be unfair to you, Doctor.
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2 3 4 5 6 7 8 9 10 11		Okay. All right. And so that we get an idea of how many surgeries you would do, all types, in this timeframe before your disagreement with Allen Hospital, how many surgeries do you think you would do in a year's time? MS. RINDEN: I'm going to object to the form. You can go ahead and answer, Doctor. Yes. I would say until again, I can't put numbers in it, but all I can tell you that I was the only cardiovascular surgeon in the Cedar Valley up until 2008 or so, so I did all	2 3 4 5 6 7 8 9 10 11	A.	I was doing high-risk procedures and I was not insurable, and that was what led to that. Because I was not insurable, I could not be part of Cedar Valley, so I left. With the membership, I left in good terms. I I got my own insurance, started my own corporation, and I'm still here. Okay. But and I don't want to be unfair to you, Doctor. Okay. I used the word "fired" as the equivalent of
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A. Q.	Okay. All right. And so that we get an idea of how many surgeries you would do, all types, in this timeframe before your disagreement with Allen Hospital, how many surgeries do you think you would do in a year's time? MS. RINDEN: I'm going to object to the form. You can go ahead and answer, Doctor. Yes. I would say until again, I can't put numbers in it, but all I can tell you that I was the only cardiovascular surgeon in the Cedar Valley up until 2008 or so, so I did all the open heart surgeries. I did most of the vascular surgeries and most of the thoracic surgeries. Are you able to give me a reasonable estimate of the number of surgeries you would do in a year back then? At one point I was doing over 1,000. Okay. All right. So if you're losing 50 to 60 percent of your open heart work, does that mean	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A. Q. A. Q. A. Q.	I was doing high-risk procedures and I was not insurable, and that was what led to that. Because I was not insurable, I could not be part of Cedar Valley, so I left. With the membership, I left in good terms. I I got my own insurance, started my own corporation, and I'm still here. Okay. But and I don't want to be unfair to you, Doctor. Okay. I used the word "fired" as the equivalent of "terminated." You used the word This is what you said. You said, "They terminated me. They kicked me out." That's what I'm saying. I'm just clarifying that. And I appreciate that. I appreciate that. Did you have any for example, did you get along with Dr. Bekavac? Yes. I still do, yes. Okay. Do you get along with Dr. Halloran? Yes. I still do.
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EROMOSELE OTOADESE, M.D. 5-8-18

				ESE, N	1.D.	5-8-18	26
			24	1		interacted in knowing what firsthand	20
			Working relationship, no. I get along with	1		interested in knowing what firsthand	
	2		everybody.	2		information you have.	hut
			Okay. All right. As you sit here, I know	3		Okay. I don't have firsthand information, I	
	4		you're aware that Dr. Bekavac has written	4		I can tell you from what you have just said	1
	5		he's got a medical record that talks about his	5		that we were all very close friends. Very	
(6		viewpoint of what happened with Mr. McGrew. 1	6		close, all of us. Cammoun Dr. Cammou	
•	7		assume you've had a chance to look at that?	7		Dr. Bekavac, Dr. Halloran and I. We we	3 010
1			Yes, I have.	8		things together.	
:	9		Okay. And I assume you've seen Dr. Halloran's	9		Okay.	
10	0		interpretation of the CT angiogram done on	10	Α.	Especially with Dr especially between -	
1			Mr. McGrew on August 18th of 2014?	11		with with Dr. Bekavac. Bekavac, Camn	
1			Yes, I have.	12		and I, we're very, very close. And Bekava	
1			I assume you disagree with both of them.	13		Halloran were partners, too, but over the	
1			Yes, I do.	14		something has happened that they're no l	
1	5		Okay. Do you have an explanation for why	15		partners, and something has happened th	
1			they've taken the position that they've taken?	16		we all we all don't socialize like we used	d
1	7	Α.	No, I can't I can't second-guess them. I	17		to be like we used to do.	
1	8		don't you know.	18		But I don't – I don't have – I don't	
1	9	Q.	Do you think there's any bad faith on their	19		think there's anything personal between -	
2	0		part, either one? Any malice or any ill will	20		against me from them, but I do I do thin	
2	1		toward you that would explain why they have	21		that there there is between Dr. Cammo	
2	2		taken the position they've taken in these	22		and and Dr. Halloran and Dr. Bekavac,	
2	3		documents?	23		again, it's Dr. Cammoun's story to tell if h	е
2	4		MS. RINDEN: I'm going to object to the	24		wants to tell it.	
2	5		form. It's vague and asking for speculation on	25	Q.	Okay. All right. So I want to switch subje	ects
			25				27
	1		this doctor's part.	1		with you if I can. Historically for you, whe	
	2		You can go ahead and answer.	2		it comes to doing removal of plaque from	
	3	Α.	There was me, I don't think so but they they	3		carotid arteries, what has been the techn	
	4		may have disagreement with the my	4		that you use? Is it an open technique or	
	5		co-defendant. I know that, but I know that	5		you use an endovascular technique or is	it
	6		there's some serious problems between them, but	6		both?	
	7		that's not my story to tell.	7	Α.	Both.	
	8	Q.	Okay. Well, I'm interested in that. Is	8	Q.	What makes the determination for you as	
	9		there is there something about the	9		whether you're going to do it open versus	3
1	.0		relationship between those two that is,	10		endovascularly?	
1	.1		Dr. Bekavac, Dr. Halloran and Dr. Cammoun	11	Α.	Well, they are there are anatomic	
1	2		that we need to know about?	12		considerations, for example, based on the	e CT or
. 1	.3	Α.	I think there is, but it's not my story to	13		whatever image and study you do. The -	the
1	4		tell. You'll be you'll be talking to	14		For example, if the carotid artery is tortuc	ous,
1	ι5		Dr. Cammoun, and if he wants to tell it, he'll	15		then it's not safe to put a stent in it becau	ise
1	16		tell it because I'd be speculating.	16		the stents don't bend, so if it's tortuous,	
1	17	Q.	Well, and I appreciate that, Doctor, but if you	17		that would be one.	
1	18		have information about that - in other words,	18		If the aortic arch has this anatomic	
1	19		if you know it firsthand, meaning you've	19		variation, what is called a type 2 or a type	э 3
2	20		witnessed some disagreement or you've heard	20		aortic arch, it's not ideal to put a stent in	
2	21		Dr. Bekavac or Dr. Halloran say bad things	21		because the way the carotid artery come	S
	22		about Dr. Cammoun, for example, or you've heard	22		common carotid artery comes out of the	aortic
	23		Dr. Cammoun say, "These people are out to get	23		arch, it's not straight and it it would be	
1	24		me," or anything like that - and I'm not	24		very difficult to make a shunt a stent fro	om
2	25		holding you to specific words I guess I'm	25		the groin to get up there. So a type 3 arc	ch
						Page	24 to 27

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		28			30
1		probably should open rather than stent.	1	Α.	Yes.
2		If a patient has had radiation to the	2	Q.	You expose the the section that you want to
3		neck, for example, and then it's not it's	3		remove the plaque from.
4		not safe to go back there to try to open	4	Α.	Yes.
5		through the radiation. A patient like that	5	Q.	You remove the plaque, and then you put a patch
6		would benefit if it can be done, would do	6		over the area that you've been working on.
7		better with a stent than open. If it's a redo	7	Α.	Yes.
8		operation in other words, patient has had	8	Q.	Okay. And the angioplasty is what? What is
9		open carotid before, it's plugged up again and	9		that?
10		you're going to go back in, and the risk for	10	Α.	That's the name. It's a patch angioplasty.
11		complications is high if you are doing a redo	11	Q.	Thank you. Okay. So what was its purpose?
12		open procedure. In a patient like that you	12		What were you trying to accomplish with this
13		want a stent because it would be easier, so it	13		procedure?
14		depends.	14	A.	Just as you described, to remove the plaque.
15	Q.	Okay. And are you board certified, Doctor?	15	Q.	Okay. Did you have any difficulty in the
16		Yes, I am.	16		procedure itself? In other words, let me give
17		How many times did you have to take the test,	17		you examples. Did you have any trouble getting
18	-	the board certification test?	18		access to and visualizing the the area where
19	A.	The board certification. I'm on my third time	19		you're working?
20		around.	20	A.	Not at all.
21	Q.		21	Q.	Did you have any trouble removing the plaque?
22		The first time twice.	22		No.
23		Okay. That's what I meant.	23	Q.	Did it take too long For example, when you
24		Yeah.	24		clamped off, did it take too long to get access
25		I was interested in the first time. Okay.	25		to and remove the plaque and get out and and
					to and ferries the plaque and get out and
		29			31
			1		
1	А.	29 Yes.	1 2	A.	31
1 2	А. Q.	29			take the clamps off?
1 2 3	A. Q. A.	29 Yes. And you're recertified, correct? Yes.	2		take the clamps off? No. Not that I recollect.
1 2 3 4	A. Q. A.	29 Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that	2 3	Q.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a
1 2 3 4 5	A. Q. A.	29 Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to	2 3 4	Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct.
1 2 3 4	A. Q. A.	29 Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a	2 3 4 5	Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct?
1 2 3 4 5 6 7	A. Q. A. Q.	29 Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9.	2 3 4 5 6	Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went
1 2 3 4 5 6 7 8	A. Q. A. Q.	29 Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay.	2 3 4 5 6 7	Q. A. Q.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just
1 2 3 4 5 6 7 8 9	A. Q. A. Q.	29 Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for	2 3 4 5 6 7 8	Q. A. Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand
1 2 3 4 5 6 7 8 9 10	A. Q. Q. Q.	29 Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits.	2 3 4 5 6 7 8 9	Q. A. Q. A. Q.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right.
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1 2 3 4 5 6 7 8 9 10 11 12 13	A. Q. A. Q.	29 Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report?	2 3 4 5 6 7 8 9 10 11 12	Q. A. Q. A. Q.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the
1 2 3 4 5 6 7 8 9 10 11 12 13 14	A. Q. A. Q. A.	29 Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report? Yes.	2 3 4 5 6 7 8 9 10 11 12 13	Q. A. Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the form.
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15	A. Q. A. Q. A.	Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report? Yes. Okay. You describe the type the operation	2 3 4 5 6 7 8 9 10 11 12 13 14	Q. A. Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the form. You can answer if you can.
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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	A. Q. A. Q. A. Q.	Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report? Yes. Okay. You describe the type the operation as a right carotid endarterectomy with is it vasatek?	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	Q. A. Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the form. You can answer if you can. I don't have an answer. I still Till this day I still ask myself what what could
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	A. Q. A. Q. A. Q. A.	Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report? Yes. Okay. You describe the type the operation as a right carotid endarterectomy with is it vasatek? Vascutek, VASCUTEK.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	Q. A. Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the form. You can answer if you can. I don't have an answer. I still Till this day I still ask myself what what could happen, because I did the operation the same
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	A. Q. A. Q. A. Q. A. Q.	Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report? Yes. Okay. You describe the type the operation as a right carotid endarterectomy with is it vasatek?	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	Q. A. Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the form. You can answer if you can. I don't have an answer. I still Till this day I still ask myself what what could happen, because I did the operation the same way I've always done them. I still do the
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A. Q. A. Q. A. Q. A. Q. A. Q.	29 Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report? Yes. Okay. You describe the type the operation as a right carotid endarterectomy with is it vasatek? Vascutek, V A S C U T E K. Thank you. Carotid patch angioplasty. Yes.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	Q. A. Q. A. Q.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the form. You can answer if you can. I don't have an answer. I still Till this day I still ask myself what what could happen, because I did the operation the same way I've always done them. I still do the operation, the open procedure, the same way.
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A. Q. A. Q. A. Q. A. Q. A. Q.	Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report? Yes. Okay. You describe the type the operation as a right carotid endarterectomy with is it vasatek? Vascutek, V A S C U T E K. Thank you. Carotid patch angioplasty. Yes. Okay. Let's try to understand. As I	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	Q. A. Q. A. Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the form. You can answer if you can. I don't have an answer. I still Till this day I still ask myself what what could happen, because I did the operation the same way I've always done them. I still do the operation, the open procedure, the same way. Nothing has changed. Okay.
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A. Q. A. Q. A. Q. A. Q. A. Q. A. Q.	29 Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report? Yes. Okay. You describe the type the operation as a right carotid endarterectomy with is it vasatek? Vascutek, V A S C U T E K. Thank you. Carotid patch angioplasty. Yes.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	Q. A. Q. A. Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the form. You can answer if you can. I don't have an answer. I still Till this day I still ask myself what what could happen, because I did the operation the same way I've always done them. I still do the operation, the open procedure, the same way. Nothing has changed.
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A.	Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report? Yes. Okay. You describe the type the operation as a right carotid endarterectomy with is it vasatek? Vascutek, V A S C U T E K. Thank you. Carotid patch angioplasty. Yes. Okay. Let's try to understand. As I understand it, this is an open procedure. Yes.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q. A. Q. A. Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the form. You can answer if you can. I don't have an answer. I still Till this day I still ask myself what what could happen, because I did the operation the same way I've always done them. I still do the operation, the open procedure, the same way. Nothing has changed. Okay. And I have never had, knock on wood, an outcome
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A.	Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report? Yes. Okay. You describe the type the operation as a right carotid endarterectomy with is it vasatek? Vascutek, V A S C U T E K. Thank you. Carotid patch angioplasty. Yes. Okay. Let's try to understand. As I understand it, this is an open procedure.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A. Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the form. You can answer if you can. I don't have an answer. I still Till this day I still ask myself what what could happen, because I did the operation the same way I've always done them. I still do the operation, the open procedure, the same way. Nothing has changed. Okay. And I have never had, knock on wood, an outcome like this. So I can't explain it.
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A.	Yes. And you're recertified, correct? Yes. Okay. Now, let's talk about the surgery that you did on on Mr. McGrew. According to I'm going to show you here I've got a document marked Exhibit 9. Okay. MR. DIAZ: I have one for George, one for you. I don't know if I have enough exhibits. According to this document, this Exhibit 9, this is the this is, by the way, the the operative report? Yes. Okay. You describe the type the operation as a right carotid endarterectomy with is it vasatek? Vascutek, V A S C U T E K. Thank you. Carotid patch angioplasty. Yes. Okay. Let's try to understand. As I understand it, this is an open procedure. Yes. So you cut in, you expose You have to clamp	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Q. A. Q. A. Q. A.	31 take the clamps off? No. Not that I recollect. Okay. Can Mr. McGrew ends up with a with a stroke. Correct? Correct. Now, someone might ask the question what went wrong, so and when I ask that, I'm just wanting to know and understand That's right. what's the relationship between what you did and what happened to Mr. McGrew? MS. RINDEN: I'm going to object to the form. You can answer if you can. I don't have an answer. I still Till this day I still ask myself what what could happen, because I did the operation the same way I've always done them. I still do the operation, the open procedure, the same way. Nothing has changed. Okay. And I have never had, knock on wood, an outcome like this. So I can't explain it. All right. Now, it's fair to say that if you

	,			
	EROMOSELE OTOADE	ESE, N	I.D.	5-8-18
	32	1		the best copy I got.
1 2	right carotid endarterectomy with this patch that you're going to explain to them that there	2		Okay.
2	are risks associated with doing that surgery.	3		I'm not saying it's a great copy, but I'm going
3 4	A. Yes.	4		to show you what's been marked as Exhibit 8.
5	Q. Okay. Did you do that here?	5		And this is a calendar, because one of the
6	A. Yes.	6		things I asked for was I wanted to know how
7	Q. All right. Who did you do that with? In other	7		many surgeries you were doing on this
8	words, who was present when you talked to	8		particular day.
9	Mr. McGrew?	9		Okay.
10	A. Mr. McGrew. His daughter for sure.	10		Or procedures. I know that doctors use the
11	Q. Okay.	11		term different than maybe that lay people do.
12	A. And I think his wife. I'm not sure, but his	12		Are you able to tell from looking at that
13	daughter was there for sure.	13		document how many different procedures you did
14	Q. And did you know his daughter?	14		on September 2nd of 2014?
15	A. Yes.	15	Α.	No. Because it's I can't read it. Only
16	Q. How did you know his daughter?	16		No.
17	A. She works in the office of one of my	17	Q.	They're look like they're little check marks
18	colleagues.	18		next to things. Do you see that there?
19	Q. And who is the colleague?	19		Yes.
20	A. It's in the Matt Smith, Dr. Matt Smith.	20	Q.	Are you able to tell us whether a check mark
21	Q. Okay. All right. So you knew her from that.	21		suggests or indicates one a procedure at
22	You sit down and you talk with Mr. McGrew, and	22		each time?
23	you explain to him the risks.	23	Α.	No. Is this from my office or where where
24	A. Yes.	24	~	is this from?
25	Q. I assume you explained to him that one of the	25	Q.	I can't tell you where it came from. I assume 35
	33	1		it came from your office.
1	risks of doing this right carotid endarterectomy with this patch is that he could	2	Δ	Office surgery calendar. No, I don't. I can't
2 3	get a stroke.	3	Λ.	tell you.
4	A. Yes.	4	Q.	Okay. Well, let's let's look let's leave
5	Q. All right. Do we know in the either in the	5		it this way: Could you check with your staff
6	literature or from your training why it is that	6		and ask them to look on September 2nd through
7	some people who undergo this procedure end up	7		your records and say tell us how many
8	with a stroke?	8		different procedures and the types of
9	A. No. I don't think there's any way to predict	9		procedures you did on that day? Is that
10	it. No. Just No.	10		something that could be done?
11	Q. Is there a Do you have a sense of what your	11	Α.	You could you could get that from the
12	complication rate is back in this timeframe	12		hospital.
13	of 2014, what your complication rate was	13		Okay. They would have those records too?
14	related to doing an open right doesn't	14	Α.	Yes, they they could tell you whether you
15	matter whether it's right or left, an	15		know, what
16	endarterectomy?	16		Okay.
17	A. One percent or less.	17		I think that would be better.
18	Q. Okay. All right. Now, it's my understanding	18	Q.	Is it customary for you to do just one surgery
19	that the following day, Mr. McGrew starts to	19		on one particular day?
20	show some symptoms or signs of of a possible	20	А.	It depends on how busy we are. Some days I do
21	stroke. Correct?	21		three or four surgeries, five, depending on
22	A. Correct.	22		depends on the operation, the complexity of the
23	Q. So I want to understand your involvement. I know that there was a document that was given	23	\cap	operation. Sure.
24 25	to us by your attorney, and I honestly, it's	24		If I'm doing an abdominal aneurysm repair, I
25	to us by your attorney, and I nonestry, it's	125	73.	Page 32 to 35

FROMOSELE OTOADESE, M.D. 5-8-18 38 36 1 can't do more than one or two a day. If I'm 1 somewhere between seven and seven-twenty in the 2 morning, he starts to show some difficulty with doing varicose vein surgery, I can do ten a 2 3 day. It really depends. Carotid, I've done 3 facial droop, some drooling, and some three in one day. 4 difficulty moving the left side of his body. 4 When are you notified of that? Q. All right. How long does it typically take you 5 5 to do this --- the surgery that you performed on 6 A. I think it's in the record. As soon as --6 7 My -- my understanding is that, at least from 7 Mr. McGrew? A. Again, it depends on the patient, but typically reading the records, his daughter had come to 8 8 pick him up the next day because he was going I would say an hour and a half to two hours. 9 9 to be discharged, and I think either she -- he 10 Q. All right. Do you know how long it took in 10 was getting dressed and he wasn't moving very this case, in his case? 11 11 MS. RINDEN: Do you want him to look at 12 well, and she got a nurse to come in to take a 12 13 the records or -look. 13 MR. DIAZ: I'm just asking if -- if he 14 Q. Okay. 14 knows. If he doesn't, we can always go look at 15 A. And the nurse came in and -- and agreed that he 15 was having trouble moving his left leg while he the records. 16 16 was trying to get dressed. And -- and I think A. No. I don't recollect. 17 17 they called me right away to say he was having Q. All right. Was it your impression that it took 18 18 19 roughly the same amount of time that it 19 problems, and -- and I came in. normally takes, an hour and a half to two? 20 Q. Okay. And were you able to tell at what time 20 A. Yeah. I don't -- I don't remember or recollect 21 these symptoms had developed, had started? 21 A. I've looked at the records. I don't -- I anything unusual or in particular. 22 22 Q. Okay. Now, so tell me, do you have any memory 23 can't tell. I just -- You know, I don't know. 23 of anything that happened to Mr. McGrew after 24 I can't tell you. 24 Q. Okay. So let's say you're there at, let's say, 25 you were done with his procedure and before 25 37 39 midnight of that same day? eight o'clock in the morning, as an example. 1 1 A. No. I mean typically we're done with the 2 You're there. I think the records show that 2 there was an Allyson -- is it Landfair? 3 3 operation, you -- you wake the patient up in the room and make sure there are no deficits 4 A. Yes. She's my nurse practitioner. 4 Q. Yeah. She's one of your staff people. She they wake up, and then you go to the recovery 5 5 makes contact with the nurse around 6 room. They're in the recovery room for some 6 seven-forty, so I'm going to use eight o'clock time. The recovery room nurses determine how 7 7 long they stay in the recovery room, a lot of 8 as just an example. Let's say at eight o'clock 8 you're -- you're now aware that this patient other factors, and determines when they leave 9 9 has shown some signs or symptoms of possible recovery room. If -- if the patient is 10 10 doing -- is progressing as expected, then they 11 stroke. What are your -- what are your options 11 12 at this point? What can you do if, in fact, go from recovery room to their room, whether 12 13 this patient has a stroke? ICU or the regular floor. 13 Q. All right. A. Well, depending on -- First thing you -- you 14 14 A. But up until the patient went to the floor, 15 want to get a study to see -- you know, get a 15 because I went with them -- I -- usually I go 16 CAT scan. That's the first thing. 16 with all my patients to the recovery room, and 17 Q. Okay. 17 A. If he has -- Because you want to start -- you then I -- when they get settled in recovery 18 18 room I go talk to the family, and then I go to 19 want to anticoagulate them but you also -- you 19 my office, I do whatever else I have to do. 20 want to know if they're bleeding in the brain, 20 and if they are, you don't want to 21 21 And that's -- As far as I know, there was 22 anticoagulate them, so you take them to CAT 22 nothing -- there was no -- no complication with scan to check for a head bleed. me as far as being notified that there was 23 23 anything going on until the next morning. 24 Q. And the CAT scan in his case showed there was 24 25 O And it looks like from the records that around no bleeding. 25 Page 36 to 39

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1	Δ	40 Right.	1	0	That's fine. I just want to know if you knew.
2		Correct? So at that point now you know that,	2	ч.	So at this point after the MRI, you're pretty
3	ч.	so what are your options at this point with	3		satisfied that that this man has sustained
4		this patient?	4		some kind of a stroke, some kind of damage to
5	А	Well, I was there. I saw him and I saw he	5		the brain?
6	/	he had some some movement. He he wasn't	6	A.	Yes.
7		moving very well, but he's and and	7	Q.	And so let's forget about Dr. Hassani for a
8		because I did not know how long this had been	8		second. Let's talk about you.
9		going on it may have happened at midnight,	9	A.	Yes.
10		we don't know. At that point my my option	10	Q.	What do you think should be done at that point?
11		was just to anticoagulate him and watch him.	11		Just watch him. Anticoagulate him and watch
12		Give him some time.	12		him to see what function what function
13	Q.	Okay. All right. If you had known what time	13		recovers.
14		it had happened for example, when the first	14	Q.	Okay. But Dr. Hassani apparently thinks maybe
15		symptom had started - does that somehow change	15		you should take him back to surgery. Why does
16		what you can do for the patient?	16		he want you to take him back to surgery?
17	A.	Yes. If he was in recovery room and he and	17	A.	I can't
18		he was having these problems, we go right back	18		MS. RINDEN: I'm going to Hold on just
19		to surgery.	19		a second, Doctor; excuse me. I'm going to
20	Q.	Okay.	20		object to the form. Vague, and it calls for
21		If that happened, yes.	21		speculation.
22		Now, I know from reading the records there was	22		You can answer if you know.
23		a doctor a neurologist I've got to be	23	Q.	Well, Doctor, let me I'm not interested in
24		honest, I'm going to have a hard time	24		having you speculate. I assume that you would
25		pronouncing that doctor's name.	25		have spoken to Dr. Hassani if Dr. Hassani wants
		41			43
1	Α.	Hassani, we call him. Hassani.	1		you to take this patient back, right?
2	Ο				
	ω,	Hassani? Okay.	2	Α.	I spoke to him but
3		Hassani? Okay. For short.	2 3		I spoke to him but So what did he say to you is what I'm
3 4	A.	-		Q.	So what did he say to you is what I'm interested in knowing.
	A.	For short.	3	Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take
4	A. Q. A.	For short. That's a that's a shortened version of his name. Yeah.	3	Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the
4 5	A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use	3 4 5	Q. A.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid.
4 5 6	A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants	3 4 5 6	Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him?
4 5 6 7	A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient	3 4 5 6 7 8 9	Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that
4 5 6 7 8	А. Q. Q.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true?	3 4 5 6 7 8	Q. A. Q. A.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point.
4 5 7 8 9	А. Q. Q.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an	3 4 5 6 7 8 9 10 11	Q. A. Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that?
4 5 7 8 9 10	A. Q. A. Q.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done.	3 4 5 6 7 8 9 10 11 12	Q. A. Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how
4 5 7 8 9 10	A. Q. A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay.	3 4 5 6 7 8 9 10 11 12 13	Q. A. Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I
4 5 7 8 9 10 11 12 13 14	A. Q. A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some	3 4 5 6 7 8 9 10 11 12 13 14	Q. A. Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight
4 5 7 8 9 10 11 12 13 14 15	A. Q. A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some time transpired and then he called me, yes, and	3 4 5 6 7 8 9 10 11 12 13 14 15	Q. A. Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert
4 5 7 8 9 10 11 12 13 14 15 16	A. Q. A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some time transpired and then he called me, yes, and wanted suggested that the patient should go	3 4 5 6 7 8 9 10 11 12 13 14 15 16	Q. A. Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert it from an ischemic stroke to a hemorrhagic
4 5 7 8 9 10 11 12 13 14 15	A. Q. A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some time transpired and then he called me, yes, and wanted suggested that the patient should go back to surgery.	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	Q. A. Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert it from an ischemic stroke to a hemorrhagic stroke. When you open up a clot like that, it
4 5 7 8 9 10 11 12 13 14 15 16 17 18	A. Q. A. Q. A. Q.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some time transpired and then he called me, yes, and wanted suggested that the patient should go back to surgery. What did that MRI show?	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	Q. A. Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert it from an ischemic stroke to a hemorrhagic stroke. When you open up a clot like that, it turns into a head bleed, which could be fatal.
4 5 7 8 9 10 11 12 13 14 15 16 17 18 19	A. Q. A. Q. A. Q.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some time transpired and then he called me, yes, and wanted suggested that the patient should go back to surgery. What did that MRI show? I don't recollect. That the carotid was	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	Q. A. Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert it from an ischemic stroke to a hemorrhagic stroke. When you open up a clot like that, it turns into a head bleed, which could be fatal. Okay. So your your your concern is we're
4 5 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A. Q. Q. A. Q. A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some time transpired and then he called me, yes, and wanted suggested that the patient should go back to surgery. What did that MRI show? I don't recollect. That the carotid was occluded.	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	Q. A. Q. A. Q.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert it from an ischemic stroke to a hemorrhagic stroke. When you open up a clot like that, it turns into a head bleed, which could be fatal. Okay. So your your your concern is we're already we're already dealing with an
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A. Q. Q. A. Q. A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some time transpired and then he called me, yes, and wanted suggested that the patient should go back to surgery. What did that MRI show? I don't recollect. That the carotid was occluded. Okay. And what did it show in terms of damage	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	Q. A. Q. A. Q. A.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert it from an ischemic stroke to a hemorrhagic stroke. When you open up a clot like that, it turns into a head bleed, which could be fatal. Okay. So your your your concern is we're already we're already dealing with an ischemic stroke.
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q. A. Q. A. Q. A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some time transpired and then he called me, yes, and wanted suggested that the patient should go back to surgery. What did that MRI show? I don't recollect. That the carotid was occluded. Okay. And what did it show in terms of damage to the brain, do you know?	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q. A. Q. A. Q. A.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert it from an ischemic stroke to a hemorrhagic stroke. When you open up a clot like that, it turns into a head bleed, which could be fatal. Okay. So your your your concern is we're already we're already dealing with an ischemic stroke. Yes.
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q. A. Q. A. Q. A. Q. A. Q. A.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some time transpired and then he called me, yes, and wanted suggested that the patient should go back to surgery. What did that MRI show? I don't recollect. That the carotid was occluded. Okay. And what did it show in terms of damage to the brain, do you know? I don't recollect.	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A. Q. A.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert it from an ischemic stroke to a hemorrhagic stroke. When you open up a clot like that, it turns into a head bleed, which could be fatal. Okay. So your your your concern is we're already we're already dealing with an ischemic stroke. Yes. That is, there's been blood flow cut off to the
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A. Q.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some time transpired and then he called me, yes, and wanted suggested that the patient should go back to surgery. What did that MRI show? I don't recollect. That the carotid was occluded. Okay. And what did it show in terms of damage to the brain, do you know? I don't recollect. Okay.	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Q. A. Q. A. Q. A.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert it from an ischemic stroke to a hemorrhagic stroke. When you open up a clot like that, it turns into a head bleed, which could be fatal. Okay. So your your your concern is we're already we're already dealing with an ischemic stroke. Yes. That is, there's been blood flow cut off to the brain, which is causing a lack of oxygen and
4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A. Q.	For short. That's a that's a shortened version of his name. Yeah. Okay. So Dr. Hassani we're going to use that for today comes in and he wants apparently he wants you to take this patient back to surgery. Is that true? Not immediately. He came in and he wanted an MRI done. Okay. So patient was taken to MRI and and some time transpired and then he called me, yes, and wanted suggested that the patient should go back to surgery. What did that MRI show? I don't recollect. That the carotid was occluded. Okay. And what did it show in terms of damage to the brain, do you know? I don't recollect.	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A. Q. A.	So what did he say to you is what I'm interested in knowing. He just said, you know, I think I should take him take him back to try and open up the carotid. And what did you say to him? I said no. I don't think it's safe to do that at this point. And why isn't it safe to do that? Because the first place we don't know how how long the process had been going on, as I said earlier. It may have happened at midnight or 2 a.m. The second place, you could convert it from an ischemic stroke to a hemorrhagic stroke. When you open up a clot like that, it turns into a head bleed, which could be fatal. Okay. So your your your concern is we're already we're already dealing with an ischemic stroke. Yes. That is, there's been blood flow cut off to the

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	•	44			
1		Yes.	1		and also told them I wasn't certain that taking
2	Q.	Okay. Your concern is if we go back in, we	2		him back to surgery is going to recover is
3		could make this turn this into a situation	3		going to make him recover the lost function.
4		where it starts to bleed into the brain.	4	~	If anything, it it could make this worse.
5		Yes.	5	Q.	Okay. And what was the family's response to
6	Q.	Thereby expanding or or compressing what's	6		this?
7		left in the brain. Correct?	7	А.	Well, they agreed you know, they agreed
8		Yes. It's fatal.	8		they they agreed in spite of the risks, so I
9	Q.	All right. Now, at some point, and I don't	9	-	took him.
10		know the time exactly, but maybe we could find	10	Q.	Okay. But what was their motive? What was
11		it in your records; somewhere I read three	11		what was motivating them to say, "Look, Doctor,
12		o'clock in the afternoon. I'm not particularly	12		we want you to" "we want you to go ahead and
13		focused on the time, I'm more interested in	13		do this second surgery"? What were they
14		apparently you at some point agree to go back	14		telling you?
15		in and do that. Tell me what led you to to	15	Α.	I can't I can't tell you what their
16		go back in and do a second surgery on	16		motivation was. I do know that I came down to
17		Mr. McGrew.	17		talk to them. You know, there was somebody
18	Α.	Dr. Hassani called me later on, several hours	18		was crying. Everything going on there in the
19		later, and said that he had spoken to a	19		midst of all the confusion, but
20		vascular surgeon at an outside hospital who has	20		Well
21		agreed to operate on the patient, and he was	21	Α.	I can't tell you what their motivation was,
22		going to transfer the patient to the	22		but
23		hospital to another hospital for operation,	23	Q.	Well, again, I'm not interested in you having
24		and at that that that's I disagreed.	24		to try to figure out what's in their heads.
25		l said, "No. I won't" "I won't let you	25		I'm more interested in knowing what they said
			1		·
<u> </u>		45.			47
1		do that. He is my patient, I did the	1		to you as to why they wanted you to proceed
2		do that. He is my patient, I did the operation. I would not let you take him	2		to you as to why they wanted you to proceed anyway.
2 3		do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the	2 3	A.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them
2 3 4		do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest	2 3 4	A.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to
2 3 4 5		do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk	2 3 4 5	A.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then
2 3 4 5 6		do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know	2 3 4 5 6		to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back.
2 3 4 5 6 7		do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it,	2 3 4 5 6 7		to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back. And was it your understanding that they had
2 3 4 5 6 7 8		do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it, we'll take him."	2 3 4 5 6 7 8	Q.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back. And was it your understanding that they had They had been speaking to Dr. Hassani, correct?
2 3 4 5 6 7 8 9		do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it, we'll take him." Okay.	2 3 4 5 6 7 8 9	Q <i>.</i> A.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back. And was it your understanding that they had They had been speaking to Dr. Hassani, correct? I assume they had been.
2 3 4 5 6 7 8 9 10	А.	do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it, we'll take him." Okay. So I took him.	2 3 4 5 6 7 8 9 10	Q <i>.</i> A.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back. And was it your understanding that they had They had been speaking to Dr. Hassani, correct? I assume they had been. Okay. All right. Are you critical at all of
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2 3 4 5 7 8 9 10 11 12 13	A. Q. A.	do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it, we'll take him." Okay. So I took him. And so who did you speak to in the family? The family. There were there were By now there were a bunch of people there.	2 3 4 5 6 7 8 9 10 11 12 13	Q. A. Q. A.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back. And was it your understanding that they had They had been speaking to Dr. Hassani, correct? I assume they had been. Okay. All right. Are you critical at all of the family for asking you to go back and and do a second surgery? Not at all, no.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	А. Q. А. Q. А.	do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it, we'll take him." Okay. So I took him. And so who did you speak to in the family? The family. There were there were By now there were a bunch of people there. Okay. I think his wife, his daughter, a few other people. I don't recollect exactly, but All right. And I know you're not going to remember everything you told them. I'm not expecting you to, but can you give us an idea	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	Q. A. Q. Q.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back. And was it your understanding that they had They had been speaking to Dr. Hassani, correct? I assume they had been. Okay. All right. Are you critical at all of the family for asking you to go back and and do a second surgery? Not at all, no. All right. Okay. Did anything happen as a result of the second surgery? In other words, did did you go back in and did you create this you know, inadvertent necessarily, bleeding? Did anything like that happen during the second surgery?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	А. Q. А. Q. А.	do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it, we'll take him." Okay. So I took him. And so who did you speak to in the family? The family. There were there were By now there were a bunch of people there. Okay. I think his wife, his daughter, a few other people. I don't recollect exactly, but All right. And I know you're not going to remember everything you told them. I'm not expecting you to, but can you give us an idea of what kinds of things you wanted to share	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	Q. A. Q. A. A.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back. And was it your understanding that they had They had been speaking to Dr. Hassani, correct? I assume they had been. Okay. All right. Are you critical at all of the family for asking you to go back and and do a second surgery? Not at all, no. All right. Okay. Did anything happen as a result of the second surgery? In other words, did did you go back in and did you create this you know, inadvertent necessarily, bleeding? Did anything like that happen during the second surgery? No.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	А. Q. А. Q. А.	do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it, we'll take him." Okay. So I took him. And so who did you speak to in the family? The family. There were there were By now there were a bunch of people there. Okay. I think his wife, his daughter, a few other people. I don't recollect exactly, but All right. And I know you're not going to remember everything you told them. I'm not expecting you to, but can you give us an idea of what kinds of things you wanted to share with them in terms of making a decision? Well, I told them that this is not safe, that	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q. A. Q. A. Q. A.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back. And was it your understanding that they had They had been speaking to Dr. Hassani, correct? I assume they had been. Okay. All right. Are you critical at all of the family for asking you to go back and and do a second surgery? Not at all, no. All right. Okay. Did anything happen as a result of the second surgery? In other words, did did you go back in and did you create this you know, inadvertent necessarily, bleeding? Did anything like that happen during the second surgery? No. What was the goal of the second surgery? What were you trying to accomplish?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q. A. Q. Q.	do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it, we'll take him." Okay. So I took him. And so who did you speak to in the family? The family. There were there were By now there were a bunch of people there. Okay. I think his wife, his daughter, a few other people. I don't recollect exactly, but All right. And I know you're not going to remember everything you told them. I'm not expecting you to, but can you give us an idea of what kinds of things you wanted to share with them in terms of making a decision? Well, I told them that this is not safe, that it could it could turn it could As I	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A. Q. A. Q. A.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back. And was it your understanding that they had They had been speaking to Dr. Hassani, correct? I assume they had been. Okay. All right. Are you critical at all of the family for asking you to go back and and do a second surgery? Not at all, no. All right. Okay. Did anything happen as a result of the second surgery? In other words, did did you go back in and did you create this you know, inadvertent necessarily, bleeding? Did anything like that happen during the second surgery? No. What was the goal of the second surgery? What were you trying to accomplish? To reestablish blood flow to the brain.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	A. Q. A. Q. Q.	do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it, we'll take him." Okay. So I took him. And so who did you speak to in the family? The family. There were there were By now there were a bunch of people there. Okay. I think his wife, his daughter, a few other people. I don't recollect exactly, but All right. And I know you're not going to remember everything you told them. I'm not expecting you to, but can you give us an idea of what kinds of things you wanted to share with them in terms of making a decision? Well, I told them that this is not safe, that it could it could turn it could As I have just said, it could turn it into a	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Q. A. Q. A. Q. A. Q. A. Q.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back. And was it your understanding that they had They had been speaking to Dr. Hassani, correct? I assume they had been. Okay. All right. Are you critical at all of the family for asking you to go back and and do a second surgery? Not at all, no. All right. Okay. Did anything happen as a result of the second surgery? In other words, did did you go back in and did you create this you know, inadvertent necessarily, bleeding? Did anything like that happen during the second surgery? No. What was the goal of the second surgery? What were you trying to accomplish? To reestablish blood flow to the brain. Were you able
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q. A. Q. Q.	do that. He is my patient, I did the operation. I would not let you take him somewhere to a surgeon who doesn't know the patient, and he doesn't have a vested interest in the patient like I do. No, let me come talk to the family, talk to them and let them know that this is high risk, but if they want it, we'll take him." Okay. So I took him. And so who did you speak to in the family? The family. There were there were By now there were a bunch of people there. Okay. I think his wife, his daughter, a few other people. I don't recollect exactly, but All right. And I know you're not going to remember everything you told them. I'm not expecting you to, but can you give us an idea of what kinds of things you wanted to share with them in terms of making a decision? Well, I told them that this is not safe, that it could it could turn it could As I	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A. Q. A. Q. A. Q.	to you as to why they wanted you to proceed anyway. They didn't say why. They just I told them the risks. Do they still want to go to surgery, take him back; yes. So, okay, then we'll take him back. And was it your understanding that they had They had been speaking to Dr. Hassani, correct? I assume they had been. Okay. All right. Are you critical at all of the family for asking you to go back and and do a second surgery? Not at all, no. All right. Okay. Did anything happen as a result of the second surgery? In other words, did did you go back in and did you create this you know, inadvertent necessarily, bleeding? Did anything like that happen during the second surgery? No. What was the goal of the second surgery? What were you trying to accomplish? To reestablish blood flow to the brain.

		EROMOSELE OTOAI 48	DESE, I	M.D.	5-8-18 50
1		artery was occluded, a thrombosis.	1		We still don't know how much function we get
2	Q.	Occluded meaning?	2		back, you know.
3		There was a blood clot there.	3	Q.	Okay.
4		So if we if we talk in terms of a of a	4		We've known people who have had stroke, and
5	ч.	highway and you're trying to get through that	5		with hard work and all that were able to get
6		highway, that highway was completely blocked.	6		back some function. I said, "Just have him
7	Α	Blocked, yeah.	7		keep working."
8		Okay. And were you able to remove to create	8	Q.	All right. Did you ever apologize to the
9	~.	space so that blood could flow through to the	9	-47	family at any point?
10		brain?	10	A.	Apologize. I don't get Apologize for what?
11	А	Yes.	11		I'm just asking you if you ever apologized.
12		Do you have an opinion as you sit here as to	12	_	Sometimes people will say, "I'm sorry. I feel
13	<u> </u>	whether the stroke that Mr. McGrew suffered and	13		responsible." You know, people say that. I'm
13		the problems that he suffered were related	14		not interested in your motivation, I'm
15		solely to the first surgery or partly related	15		interested in whether you ever said those
15		to the second surgery or anything like that?	16		words.
10	А	I have no opinion that I I don't think	17	Α.	I think I have. I I don't recollect it, but
18	7	that the second surgery hurt anything or	18	<i>,</i>	think I I've I talked to to them
19		improved it. I think nothing changed.	19		immediately, said, "I'm sorry this happened,
20	0	Okay. All right. And do you have an opinion	20		but there's no way of predicting what" "what
21	٠.	as to what would have happened to him if you	21		will happen, but we just need to give it time,
22		chose not to do the second surgery; in other	22		see what" – "how much function he recovers."
23		words, left this right carotid artery occluded,	23	Q.	Okay.
24		how that would have played out in terms of his	24	۰.	MS. RINDEN: Marty, we've been going about
25		either getting better or getting worse?	25		an hour. Would now be a good time for a break?
					51
1					
	Α.	No.	1		MR. DIAZ: Sure. Sure. Let me let
2		No. You don't have any opinion.	1	. *	MR. DIAZ: Sure. Sure. Let me let me let me just double-check to make sure.
2 3	Q.				
	Q. A.	You don't have any opinion.	2	. *	me – let me just double-check to make sure. I
3	Q. A.	You don't have any opinion. No.	2 3		me – let me just double-check to make sure. I want to finish –
3 4	Q. A.	You don't have any opinion. No. Okay. All right. Now, I don't know whether –	2 3 4		me – let me just double-check to make sure. I want to finish – MS. RINDEN: Sure.
3 4 5	Q. A.	You don't have any opinion. No. Okay. All right. Now, I don't know whether – when these conversations took place, but the	2 3 4 5		me – let me just double-check to make sure. I want to finish – MS. RINDEN: Sure. MR. DIAZ: – what I've got here and then
3 4 5 6	Q. A.	You don't have any opinion. No. Okay. All right. Now, I don't know whether – when these conversations took place, but the family recalls having conversations with you in	2 3 4 5 6		 me – let me just double-check to make sure. I want to finish – MS. RINDEN: Sure. MR. DIAZ: – what I've got here and then we'll take a break.
3 4 5 6 7	Q. A.	You don't have any opinion. No. Okay. All right. Now, I don't know whether – when these conversations took place, but the family recalls having conversations with you in which you indicated – you know, you sort of	2 3 4 5 6 7		me – let me just double-check to make sure. I want to finish – MS. RINDEN: Sure. MR. DIAZ: what I've got here and then we'll take a break. I'm looking at my notes and I think I
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EROMOSELE OTOADESE, M.D. 5-8-18 54 52 for Mindy Parson. She's one of my techs. A. Yes. 1 1 Q. Thank you. Okay. And so then let's talk about 2 Q. Can you tell us what the -- what the ultrasound 2 that was done in - Was that done in your 3 18. You then - This is your note from the 3 office or is that some - done someplace else? visit, and you say, "Patient's here for his 4 4 first postop visit." Start there. 5 5 A. I don't know. A. Yes. 6 6 7 Q. Okay. In any event, what does this ultrasound 7 Q. Okay. And you say - A little further down show? you say, "Unfortunately, he suffered a stroke 8 8 the next day," which you're talking about the 9 A. You're looking at Exhibit 17? 9 Q. Yes. 10 day after the surgery. 10 A. Okay. The impression is the right internal A. Yes. 11 11 Q. All right. And apparently there was a feeding carotid is occluded, and there are no 12 12 tube that had been placed for him to help him detectable Doppler signals in the artery. 13 13 Q. So what does that mean? get food in. 14 14 A. It means it's blocked, like you said earlier, 15 A. Yes. 15 like a highway's blocked. Q. Okay. And then you make reference to the -16 16 the ultrasound that we just talked about. Q. Okay. 17 17 A. So you can't see. You usually put the 18 A. Yes. 18 ultrasound probe and there's no signal, which Q. And here you say that the left ICA is about 50 19 19 meant there's nothing going through it. And percent stenotic. 20 20 then it's a large heterogeneous plaque in the 21 A. Yes. 21 Q. Does that mean that you actually looked at the left bifurcation and I see 50 to 79 percent. I 22 22 ultrasound as well? was talking about the upper left side. 23 23 A. Images, yes. 24 Q. All right. Let me stop you there and ask you, 24 25 did you recommend surgery on the left carotid 25 Q. Okay. 55 53 A. I do the interpretation and they send images. artery? 1 1 Q. Does MEP, does that person also do - give A. Did I? 2 2 Q. Yes. impressions and findings or -- or is it 3 3 something that you do? 4 A. No. 4 A. They do, the technologists. They give the 5 Q. Does that -- does that finding of a large 5 impression, and then I read it if I agree with plaque in the left internal carotid artery 6 6 suggest you need to do surgery on that or not? 7 it. 7 Q. So 17, Exhibit 17, which is the ultrasound, the A. Not at - You know, when they are not 8 8 discussion of the ultrasound, those findings symptomatic because the 50 to 79, it's -- it's 9 9 a wide range, so if you're considering surgery, are from the tech, and then you read them 10 10 yourself. you have to -- you do an angiogram or 11 11 something. A. Yes. 12 12 Q. Okay. Then I want to just slide down a little Q. Okay. What if they come from outside of your 13 13 bit. There's some initials there that I don't 14 office; in other words, somebody else does 14 understand. Maybe you can explain them to me. the - the ultrasound study. Do you then 15 15 It says "DVD1231" dash "5." What is that? review the ultrasound itself, or do you only 16 16 A. That's the -- All the images are recorded. look at the report? 17 17 You make a DVD of it. A. I look at the report because I don't have 18 18 Q. And is the MEP, is that the person who did the access to it, and that's one of the problems 19 19 with ultrasound that's done in different labs. imaging? 20 20 The quality you don't know. The -- With A. Yes, the ultrasound technologist. 21 21 Q. Okay. And can you tell from that, those 22 carotid - With vascular ultrasound actually, 22 initials, whether that person worked for you or they -- it's -- it's technician dependent. 23 23 Depend on who is doing it. If you know the for somebody else? 24 24 technologist, you know the quality of their A. Yes, she is -- That's -- Those initials stand 25 25

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EROMOSELE OTOADESE, M.D. 5-8-18 58 56 don't call to notify us that you're not coming work and it's an accredited lab, then it 1 1 so we can use the room, there's going to be a carries more weight than if you don't know who 2 2 did it. 3 fee. 3 Q. Okay. Now, I'm just going to show you Exhibit 4 Q. Okay. And that's what this was. 4 22, and before I do that, let me -- if you look 5 A. Yes. 5 at Exhibit 18 at -- toward the bottom under Q. Okay. And this fee comes from your office, 6 6 though; right? 7 Plan, it says, "We will add him in our recall 7 list and follow him with carotid duplex 8 A. Yes. 8 Q. I want to talk now about sort of the things 9 ultrasound in three months for surveillance." 9 that lead up to the decision to do surgery. A. Yes. 10 10 Q. What does that mean? A. Okay 11 11 A. We follow them to see how things are going, you Q. And in that I want to talk about that 12 12 13 timeframe, so roughly the summer of 2014. We 13 know. had talked earlier about what surgery you had Q. Okay. I want to show you Exhibit 22, and 14 14 done in the past, how many -- what percentage apparently there must have been a scheduled 15 15 was this, what percentage was that. Can you visit for December 30th. Would that be 16 16 consistent with this coming back to do an 17 tell us what percentage of your work, 17 ultrasound in three months? 18 surgeries, was vascular, what was nonvascular 18 A. December -- This is scheduled visit for --19 thoracic, and what would still be considered 19 cardiac that you were still doing in the summer Sorry, I missed that question. 20 20 of 2014. Q. Sure. If you look at the -- If you look in 21 21 A. Cardiac, zero. So I would say 75, 80 percent the document itself, in the middle of the 22 22 document, there is a date of December 30th of 23 cardio -- sorry, vascular and then 20 23 percent -- 20 to 25 percent noncardiac 2014. Apparently Mr. McGrew didn't show up for 24 24 25 a visit, and there was a fee charged by your 25 thoracic. 59 57 1 Q. Okay. So the name of your clinic is Northern office, a no show fee. Do you see that? 1 Iowa Cardiovascular Thoracic Surgery. 2 A. Yes, I see it, but ---2 Q. Does that --3 A. Correct. 3 Q. Correct? A. -- I don't know anything about it. 4 4 Q. Does that tell us the date that he was supposed 5 5 A. Correct. Q. And what part is cardio, then, of your to come back then? 6 6 A. That would be my guess, but -- yes. 7 surgeries? 7 Q. Okay. And apparently then your office must A. Cardiovascular. It's, you know, circulation, 8 8 blood vessels, hearts, everywhere. That's what have collected some amount of money on that no 9 9 show fee because there's a payment of five cardiovascular. 10 10 Q. Okay. So in terms of the -- When you talk dollars on there. Do you see that? 11 11 about 75 to 80 percent of the vascular, it A. Yes, I see it. 12 12 would be everything but open heart. 13 Q. Okay. Now --13 A. Do you want me to explain that or I don't 14 A. Yes. 14 15 Q. Okay. So let's talk about Mr. McGrew. He get ---15 comes to you I believe it's August 18th of Q. If you have an explanation, sure. 16 16 A. For -- Yes. Because we -- It's typical for 17 2014. That's the first time you see him. 17 most labs when patients don't show up because a 18 A. Correct. 18 lot of patients will schedule and you have them Q. Okay. You will ultimately recommend surgery to 19 19 him. Correct? on the schedule and they don't come and they 20 20 A. Correct. 21 didn't call to tell you to -- to reschedule, 21 Q. All right. So -- And I presume that you -then you have that room that's not used and 22 22 they just don't show up. So because of that, 23 that the recommendation was let's do this open 23 endo -- this open carotid artery plaque removal the vascular labs have introduced or instituted 24 24 surgery with a patch. these fees. If you have an appointment and you 25 25 Page 56 to 59

	EROMOSELE (60	1	1.D.	5-8-18 62
1	A. Yes. We talked about both open vessels,	1		taking your word for it, I guess, Marty, that
2	stenting, you know. I talked about both of	2		it wasn't produced.
3	them.	3		Subject to that, do you have an
4	Q. Okay.	4		explanation or do you not know?
5	A. But but I recommended open in his	5	A.	No, I'm surprised. I don't know why it would
6	circumstance, yes.	6		not be produced.
7	Q. And explain so we have it here in the record,	1	Q.	Okay. I assume that these notes that you take
8	what is it that said to you let's not do this	8		are put into a computer of some kind?
9	endovascular technique?	9	А.	Yes.
10	A. For one thing, the CT angiogram showed the	10	Q.	All right. Has anything, and let's say in the
11	common carotid artery, the right common ca			last five years, anything changed with your
12	artery was tortuous. It wasn't straight, and	12		computer system?
13	also in that report it was also mentioned that	13	Α.	We did – Yes, we did change When I left
14	the plaque in the right internal carotid artery	14		Cedar Valley, we had to get our own EMR,
15	was mixed; in other words, calcified and soft	15		electronic medical, and - and since then we
16	plaque.	16		have changed service, but it's just recently.
17	Based on those two things, I didn't	17		Just within the last year or so we changed.
18	consider it safe to put a stent because to get	18	Q.	So there's no – If the records were created
19	a stent through the tortuous common carotid	in 19		in 2014, when Mr. McGrew was there, there's no
20	the first place, and then you put in a	20		explanation that they would have been lost in
21	through – A soft plaque a soft plaque is	21		some way
22	high risk because it's soft. It can break	22		No, no.
23	loose, and I didn't think it would be safe to	23	Q.	 for example. They should have all been
24	be pushing a stent through that soft plaque t	D 24		there, correct?
25	place the stent, so I thought it to be safest	25	Α.	Yes, they should have.
	61		~	63
1	to just open it rather than because the risk			Okay.
2	of a stroke is slightly higher with a stent	2	А.	The first time I'm hearing this. I There's
3	than open. Q. Okay. All right. Now, I want to talk about	3	0	no reason why they shouldn't produce it. Okay. So let's talk about Exhibit 23. You
4 5	that first visit.	5	ч.	indicate on here and by the way, do you
5	A. Okay.	6		how do you do these – these notes? Is this
7	Q. The first time that an attorney for Mrs. – for	7		something – Do you dictate or do you type
, 8	the McGrews asked for a set of records, the			them yourself or how does that work?
9	was no note produced for August 18th; in oth		Δ	I dictate and the secretary types it.
10	words, your history and physical and your so			Okay. So under Chief Complaint, it says,
11	of assessment of it. After the lawsuit was	11	ч.	"Patient complains of carotid stenosis." Do
12	filed, your office produced what is now mark			you see that?
13	as Exhibit 23, which is this document here,	13	A.	Where? Yes, I see that. Yeah.
14	which I want you to identify for us. What is	14		Do you really believe the patient came in and
15	Exhibit 23?	15		said, "I'm complaining here of carotid
16	A. This is the initial consultation.	16		stenosis"?
17	Q. All right.	17	Α.	No, I didn't – No.
18	A. In my office.	18		Okay.
19	Q. Do you have an explanation for why that was	sn't 19	Α.	And I – I didn't dictate that.
20	produced the first time that records were	20	Q.	Okay. So who would have dictated it, then, if
		21		you didn't dictate it?
21	asked?			
21 22	asked? MS. RINDEN: Well, hold on a second.	l'm 22	Α.	We have a form that's filled out by the nurse.
	MS. RINDEN: Well, hold on a second. going to object to the form of that. First of	l'm 22 23	A.	We have a form that's filled out by the nurse. The patient comes into the office. The patient
22	MS. RINDEN: Well, hold on a second. going to object to the form of that. First of all, I don't think it's been established that	23 24	A.	The patient comes into the office. The patient fills out a form. Before I even see the
22 23	MS. RINDEN: Well, hold on a second. going to object to the form of that. First of	23 24	A.	The patient comes into the office. The patient

FROMOSELE OTOADESE, M.D. 5-8-18 66 64 I read that correctly? gets their vitals, fill in most of what you see 1 1 there, the medications and the other things. 2 A. Correct. 2 They fill them in, and then I come and I see 3 Q. And who had referred this patient to you? 3 A. It's -- it's up there. See the referring the patient, and then I dictate and they fill 4 4 physician and provider? See up there? John in what I dictated. So a lot of those were 5 5 filled in before I even saw the patient. Musgrave, M.D. 6 6 Q. All right. So Dr. Musgrave apparently refers Q. Yeah, so -7 7 this patient for you to look at. Correct? A. So I think that chief complaint was the person 8 8 A. According to this record, yes. It's probably who filled that out wrote that. 9 9 Q. Okay. I'm trying not to step on your next Musgrave or Mauer, I'm not sure. 10 10 Q. So let's talk about this transient loss of question. So what part of Exhibit 23 comes 11 11 vision. What's the significance of that? from your dictation? 12 12 A. It's -- That's the medical language for it. A. The -- Says, "Patient is here for" --13 13 It's called amaurosis fugax. The - the most Q. So the history part. 14 14 common cause in -- in this age group will be A. -- the first part, and then the impression and 15 15 plan. carotid disease. 16 16 Q. Okay. Let's talk about Exhibit 5, which I'm Q. All right. So I want to focus with you on 17 17 those areas, if I can. In terms of the going to hand you here. This is the -- the 18 18 ultrasound that was the outside facility history, it says, "The patient has no previous 19 19 ultrasound that's been referenced in your note, history of strokes or carotid artery disease." 20 20 and is it correct to say that this ultrasound 21 Correct? 21 was done on August 6th of 2014? A. Yes. Correct. 22 22 Q. What would be history of carotid artery 23 A. Yes. 23 Q. And it's done at United Medical Park in disease? What kinds of things would tell you 24 24 that they --- that that's part of their history? 25 Waterloo. That I assume has got nothing to do 25 67 65 with your clinic. Is that correct? A. If they tell you. They will tell you, you 1 1 A. That's correct. know, that "I had a stroke before" or "I 2 2 Q. So this is one of these situations you talked had" -- yes. З 3 about earlier where you don't actually get to Q. Okay. It says, "He relates that he had an 4 4 see the ultrasound itself. episode of transient loss of vision in the 5 5 right eye several days ago." Correct? A. Correct. 6 6 Q. You only get to look at their report. A. Yes. 7 7 Q. Okay. Did the patient use "transient" or is A. Correct. 8 8 Q. Is it worthwhile to look at the ultrasound this your interpretation of what the patient 9 9 itself? shared? 10 10 A. No, it -- no. A. That's my interpretation. 11 11 Q. So, for example, if you were interested and you Q. All right. Then it says, "The episode lasted 12 12 about a minute and has not recurred." wanted to go look at the actual ultrasound that 13 13 was done, is that something you could do? A. Correct. 14 14 A. It's not something I think has been official Q. Okay. It's - I'm going to read all the way 15 15 because as I said earlier, the ultrasound you through, and then we're going to talk about all 16 16 interpret depends on the technologist, so it 17 this. 17 does not matter. If the technologist is A. Okay. 18 18 somebody you know and you believe their work, Q. "As part of the workup, a carotid duplex 19 19 then you can take a look at it. But when it ultrasound was performed at an outside 20 20 comes from an outside facility, the facility. The study showed 50 percent stenosis 21 21 technologists, they have the probe. They are of the bilateral ICAs and critical stenosis of 22 22 looking and they are recording pictures they the bilateral ECAs. Patient is now referred to 23 23 our clinic for further evaluation and want to record. So how accurate the study is 24 24 depends on the technologist, and so I would not management." 25 25

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		EROMOSELE OTOADI	ESE. N	И.D.	5-8-18
		68	, .		70
1		look at it.	1	Q.	Okay. And is is he qualified to read and
2	Q.	Okay. I understand. So, however, you had your	2		interpret ultrasounds?
3		own lab at this point or not?	З	Α.	I don't know that. He's a radiologist, but
4	Α.	Yes, I	4		he's a radiologist. He's Dr. Halloran's
5	Q.	Okay. And could you do an ultrasound in your	5		partner.
6		lab?	6	Q.	Okay. So I guess what I'm asking is if
7	Α.	If I wanted to, yes.	7		Dr. Anugu thought that the quality of the
8	Q.	Okay.	8		ultrasound that was done on this patient was
9	Α.	But the problem with that	9		not up to proper quality, what are his options?
10	Q.	ls?	10		What can he do?
11	Α.	is reimbursement. When somebody has had an	11	Α.	I don't I can't second-guess him, but I can
12		ultrasound that soon and you try to do another	12		tell you, too, that if you read his report
13		study, you don't you don't get reimbursed	13	Q.	Yeah.
14		for it.	14	Α.	toward the end he recommended he said,
15	Q.	Okay.	15		"If clinically appropriate, CT angiogram of the
16	Α.	Because the government says it's a waste of	16		neck can be considered."
17		time. He just had an ultrasound and we're not	17	Q.	I understand that.
18		going to pay for another ultrasound. The	18	Α.	Okay. That tells me that he's not too sure
19		insurance companies don't pay.	19		about it, so if you're really if you want to
20	Q.	Gotcha. Okay. So is that the reason why it	20		pursue it, get a CT angiogram.
21		wasn't done in Mr. McGrew's case?	21	Q.	Okay. So I guess my question, then, is based
22	Α.	No. I was going to I was going to do a CTA	22		on what you just said, is it your contention
23		anyway, so did not matter.	23		that you put no weight on this ultrasound, that
24	Q.	Okay. All right. So let's look at this	24		you put everything on the CTA?
25		ultrasound that was done, and let's assume for	25		MS. RINDEN: Object to the form.
		69			71
1	,	69 the sake of our discussion that the that the	1		Argumentative.
1 2		the sake of our discussion that the that the values that are found here, the numbers that	1 2		Argumentative. You can answer.
		the sake of our discussion that the that the values that are found here, the numbers that are on here, are correct. And by the way, do		A.	Argumentative. You can answer. This particular ultrasound, yes, I don't put
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A.	 the sake of our discussion that the that the values that are found here, the numbers that are on here, are correct. And by the way, do you have any reason to doubt that an ultrasound done at United Medical Park by Rajeev Anugu, A N U G U I'm not sure if I'm pronouncing that name correctly. Do you have any reason to believe that that ultrasound is not a valid, properly done ultrasound? MS. RINDEN: Object to the form. Go ahead. Dr. Anugu did not do the ultrasound. He's interpreting it. Okay. It does not say who the technologist was who did it. Okay. And so I I I don't I've seen so many poor-quality ultrasounds done that I don't even know that it's an accredited lab. I understand. So Dr. Anugu? Am I pronouncing it right? Do you know him? Yes, I do. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A.	 Argumentative. You can answer. This particular ultrasound, yes, I don't put any weight on it. Okay. All right. But let's say you did, okay? I'm going to do a hypothetical. Let's say you found that the that the ultrasound itself is created these values that are seen here. Do these - What do these values indicate in terms of well, the amount of stenosis or narrowing found on the right side of the internal carotid artery? I don't know. I don't I don't know how the values were were generated. I have no idea. I don't know where they came from. I don't know how they were generated so I can't interpret it. Well Just looking at those numbers. Yeah, I'm just looking at the numbers and asking you, is that does that suggest that this is an individual who has severe stenosis? MS. RINDEN: Are we still on the
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	EROM	IOSELE OTOADESE, N	1.D.	5-8-18	
1	MR. DIAZ: Yep.	12	0	both eyes?	
1 2	MS. RINDEN: Okay.	2		One eye, the right eye.	
2	A. Well, just looking at the numbers on th			Okay. All right. So I know that in the in	
4	I would not interpret that as 50 percen			the decision-making process to decide whether	
5	stenosis, no.	5		somebody is a candidate for endarterectomy th	
6	Q. What would you interpret it as?	6		one of the things to look at is whether the	
7	A. It's no significant disease. No disease			person is symptomatic.	
8	actually.	8	A.	Yes.	
9	Q. Right. In fact, if I understand correctly	, 9	Q.	Okay. Is the is the fact that he describes	
10	there is a there's a I don't know w			this to you, does that make this patient	
11	they call it, a society for ultrasound teo	hs 11		symptomatic?	
12	that put together sort of values and the	1	А.	Well, there are other factors you take into	
13	think everything that is peak systolic	13		consideration. The which I mentioned	
14	velocity, the PSV	14		earlier. For his age in his age range is	
15	A. Okay.	15		overwhelming. There's overwhelming evidence	Э
16	Q if it's less than a hundred twenty-five	e, 16		that amaurosis fugax in somebody his age is	
17	it's considered essentially non not	17		caused by carotid disease.	
18	particularly significant.	18	Q.	Okay.	
19	A. Yes.	19	Α.	So he had risk factors also; hypertension, for	
20	Q. Okay. And that's what happens here.	20		example. That increases the risk too. So	
21	There's there's nothing to suggest the	nere is 21		carotid disease, it's it's number one when	
22	disease on here. Correct?	22		it comes when you're evaluating a patient	
23	A. Yeah, if based on that, you look at t			who is 69 years old and amaurosis fugax, yes.	
24	numbers, yes. None of it in the exc	ept for 24	Q.	Okay. So I'm not sure if you answered my	
25	the left external carotid. That's one-se	eventy. 25		question or if I heard it correctly, so I'm	
				75	
		73		_	
1	Q. And you didn't do surgery on the left e	external 1		going to ask it just to make sure. Does that	
2	carotid.	external 1 2	۸	going to ask it just to make sure. Does that mean this patient is symptomatic?	
2 3	carotid. A. No.	external 1 2 3		going to ask it just to make sure. Does that mean this patient is symptomatic? Yes.	
2 3 4	carotid. A. No. Q. Okay. Now, the other thing on the ult	external 1 2 3 rasound 4		going to ask it just to make sure. Does that mean this patient is symptomatic? Yes. Okay. So symptomatic patient, and then the	
2 3 4 5	carotid. A. No. Q. Okay. Now, the other thing on the ult report, it says the reason for the exam	external 1 2 3 rasound 4 n is 5		going to ask it just to make sure. Does that mean this patient is symptomatic? Yes. Okay. So symptomatic patient, and then the next part of the equation is do they have do	
2 3 4 5 . 6	carotid. A. No. Q. Okay. Now, the other thing on the ult report, it says the reason for the exam amaurosis fugax?	external 1 2 3 rasound 4 1 is 5 6		going to ask it just to make sure. Does that mean this patient is symptomatic? Yes. Okay. So symptomatic patient, and then the next part of the equation is do they have do they have stenosis really. You need to know	
2 3 4 5 . 6 7	carotid. A. No. Q. Okay. Now, the other thing on the ult report, it says the reason for the exam amaurosis fugax? A. Yes.	external 1 2 3 rasound 4 1 is 5 6 7	Q.	going to ask it just to make sure. Does that mean this patient is symptomatic? Yes. Okay. So symptomatic patient, and then the next part of the equation is do they have do they have stenosis really. You need to know that, right?	
2 3 4 5 6 7 8	 carotid. A. No. Q. Okay. Now, the other thing on the ultreport, it says the reason for the examamaurosis fugax? A. Yes. Q. All right. I want to try to understand the exama and the example. 	external 1 2 3 rasound 4 n is 5 6 7 nis 8	Q. A.	going to ask it just to make sure. Does that mean this patient is symptomatic? Yes. Okay. So symptomatic patient, and then the next part of the equation is do they have do they have stenosis really. You need to know that, right? Yes.	
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2 3 4 5 7 8 9 10	 carotid. A. No. Q. Okay. Now, the other thing on the ultreport, it says the reason for the examanaurosis fugax? A. Yes. Q. All right. I want to try to understand the concept. What causes amaurosis fug A. Various causes. It could be circulator 	external 1 2 3 rasound 4 1 is 5 6 7 his 8 9 y 10	Q. A.	going to ask it just to make sure. Does that mean this patient is symptomatic? Yes. Okay. So symptomatic patient, and then the next part of the equation is do they have do they have stenosis really. You need to know that, right? Yes. Okay. And you've got At this point as you're meeting with this patient, you have an	
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		EROMOSELE OTOAD	ESE, M	1.D.	5-8-18
4	\circ	76 Are you qualified to read CTAs?	1		78 refers patients, for that matter, do you tell
1 2		No. Not officially, no.	2		them to go to Sartori or Covenant?
2		Okay. What does that mean, not officially?	3		It depends on where the patient lives and, you
4		Since I don't have a certificate to read them.	4	7	know, we give them the option.
5		Okay. But does that mean that you don't read	5	Q.	Yeah.
6	۰.	them?	6		Yes.
7	A.	I can read them. I can tell gross gross	7		But would you agree that most patients
8		things, yes.	8		generally don't know where to go or that you
9	Q.	So, for example, in Mr. McGrew's case, did you	9		sort of point me in the right direction?
10		actually read the CT angiogram that was done	10	Α.	That's true, yes.
11		after you ordered it?	11	Q.	Okay. All right. So if you tell them to go
12	Α.	Yes, I did.	12		see any particular radiologist, you're going to
13	Q.	You looked at it.	13		say, "I want you to go" "I would prefer you
14	Α.	Like Yeah, like a surgeon you look at it.	14		go to ADI."
15		Oh, yeah, this is this is critical, but I'm	15	Α.	Yes. I I do have that preference, yes.
16		not a radiologist.	16	Q.	And is that preference What's that
17	Q.	I understand that. Okay. So do you then order	17		preference based on?
18		the CT angiogram?	18	Α.	Ninety-nine percent of the time, if you order a
19		Yes.	19		study like a CTA at Allen Hospital, even
20	Q.	All right. And do you tell the patient where	20		Covenant, but I think more Allen, it's sent out
21		they should go for the CT angiogram?	21		to Visual Radiology, which is Visual
22		No.	22		Radiology, which is not even in state. I think
23	Q.	In other words, do you point them in the right	23		it's somebody in St. Paul or somewhere.
24	_	direction?	24		Sometimes it even goes abroad, and and it's
_25	<u> </u>	No.	25		read somewhere and then they they result
			1		70
	~	All right Did you tall them			79
1		All right. Did you tell them	1		they call you with the result, and that's been
2	А.	All right. Did you tell them My secretary does that.	2		they call you with the result, and that's been the case for years even as we speak and I don't
2 3	А.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places	2 3		they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a
2 3 4	A. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go?	2 3 4		they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it
2 3 4 5	A. Q. A.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want.	2 3 4 5	Q	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away.
2 3 4 5 6	A. Q. A.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to	2 3 4 5 6		they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right.
2 3 4 5 6 7	А. Q. А. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun?	2 3 4 5 6 7		they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality
2 3 4 5 6 7 8	А. Q. А. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer	2 3 4 5 6		they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there,
2 3 4 5 6 7	А. Q. Q. А.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes.	2 3 4 5 6 7 8		they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality
2 3 4 5 6 7 8	А. Q. Q. А.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI,	2 3 4 5 6 7 8 9		they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has
2 3 4 5 6 7 8 9	А. Q. А. Q. А.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way?	2 3 4 5 6 7 8 9 10		they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they
2 3 4 5 6 7 8 9 .10 11	A. Q. Q. A. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI,	2 3 4 5 6 7 8 9 10 11	A.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we
2 3 4 5 6 7 8 9 .10 11 12	A. Q. A. Q. A. Q. A. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging.	2 3 4 5 6 7 8 9 10 11 12	A.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it.
2 3 4 5 6 7 8 9 .10 11 12 13	A. Q. A. Q. A. Q. A.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging. Okay. And where is that located?	2 3 4 5 6 7 8 9 10 11 12 13	A. Q.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it. All right. And that's what happened here,
2 3 4 5 6 7 8 9 .10 11 12 13 14	A. Q. A. Q. A. Q. A.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging. Okay. And where is that located? In Waterloo on San Marnan.	2 3 4 5 6 7 8 9 10 11 12 13 14	A. Q.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it. All right. And that's what happened here, Mr. McGrew went to ADI?
2 3 4 5 6 7 8 9 10 11 12 13 14 15	A. Q. A. Q. A. Q. A.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging. Okay. And where is that located? In Waterloo on San Marnan. And where else can you go if you if you	2 3 4 5 6 7 8 9 10 11 12 13 14 15	A. Q. A.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it. All right. And that's what happened here, Mr. McGrew went to ADI? That's what happened. It happens to all of my patients. Okay. So he goes off to ADI, gets that test
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	A. Q. A. Q. A. Q. A. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging. Okay. And where is that located? In Waterloo on San Marnan. And where else can you go if you if you don't want to send somebody to ADI? Where are the alternatives? Allen Hospital, Covenant Hospital, Sartori	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	A. Q. A.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it. All right. And that's what happened here, Mr. McGrew went to ADI? That's what happened. It happens to all of my patients. Okay. So he goes off to ADI, gets that test done. When when do you get the results?
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	A. Q. A. Q. A. Q. A. Q. A. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging. Okay. And where is that located? In Waterloo on San Marnan. And where else can you go if you if you don't want to send somebody to ADI? Where are the alternatives? Allen Hospital, Covenant Hospital, Sartori Hospital. Wherever they do angiograms.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	A. Q. A.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it. All right. And that's what happened here, Mr. McGrew went to ADI? That's what happened. It happens to all of my patients. Okay. So he goes off to ADI, gets that test done. When when do you get the results? That same day or is it the next day or what is
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	A. Q. A. Q. A. Q. A. Q. A. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging. Okay. And where is that located? In Waterloo on San Marnan. And where else can you go if you if you don't want to send somebody to ADI? Where are the alternatives? Allen Hospital, Covenant Hospital, Sartori	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18	А. Q. Q.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it. All right. And that's what happened here, Mr. McGrew went to ADI? That's what happened. It happens to all of my patients. Okay. So he goes off to ADI, gets that test done. When when do you get the results? That same day or is it the next day or what is the what's
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	A. Q. A. Q. A. Q. A. Q. A. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging. Okay. And where is that located? In Waterloo on San Marnan. And where else can you go if you if you don't want to send somebody to ADI? Where are the alternatives? Allen Hospital, Covenant Hospital, Sartori Hospital. Wherever they do angiograms.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	А. Q. Q.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it. All right. And that's what happened here, Mr. McGrew went to ADI? That's what happened. It happens to all of my patients. Okay. So he goes off to ADI, gets that test done. When when do you get the results? That same day or is it the next day or what is the what's Most of the time the same day the same day
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A. Q. A. A. Q. A.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun? Not Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging. Okay. And where is that located? In Waterloo on San Marnan. And where else can you go if you if you don't want to send somebody to ADI? Where are the alternatives? Allen Hospital, Covenant Hospital, Sartori Hospital. Wherever they do angiograms. Well, you had 99 percent of your surgeries at Allen Hospital. Yes.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20	A. Q. A. Q.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it. All right. And that's what happened here, Mr. McGrew went to ADI? That's what happened. It happens to all of my patients. Okay. So he goes off to ADI, gets that test done. When when do you get the results? That same day or is it the next day or what is the what's Most of the time the same day the same day it's done, within minutes or hours.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging. Okay. And where is that located? In Waterloo on San Marnan. And where else can you go if you if you don't want to send somebody to ADI? Where are the alternatives? Allen Hospital, Covenant Hospital, Sartori Hospital. Wherever they do angiograms. Well, you had 99 percent of your surgeries at Allen Hospital. Yes. Correct?	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q. A. Q.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it. All right. And that's what happened here, Mr. McGrew went to ADI? That's what happened. It happens to all of my patients. Okay. So he goes off to ADI, gets that test done. When when do you get the results? That same day or is it the next day or what is the what's Most of the time the same day the same day it's done, within minutes or hours. Okay. Let me find the CT angiogram. So I have
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging. Okay. And where is that located? In Waterloo on San Marnan. And where else can you go if you if you don't want to send somebody to ADI? Where are the alternatives? Allen Hospital, Covenant Hospital, Sartori Hospital. Wherever they do angiograms. Well, you had 99 percent of your surgeries at Allen Hospital. Yes. Correct? Correct.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	A. Q. A. Q.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it. All right. And that's what happened here, Mr. McGrew went to ADI? That's what happened. It happens to all of my patients. Okay. So he goes off to ADI, gets that test done. When when do you get the results? That same day or is it the next day or what is the what's Most of the time the same day the same day it's done, within minutes or hours. Okay. Let me find the CT angiogram. So I have that here now. This is Exhibit 6. This is
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A. Q. A. Q.	All right. Did you tell them My secretary does that. Okay. And do you have a list of of places where they can go? They can go wherever they want. Okay. And did you recommend that they go to see Dr. Cammoun in person, but yes. I prefer studies done at ADI, yes. Okay. What's alternative to What is ADI, by the way? Advanced Diagnostic Imaging. Okay. And where is that located? In Waterloo on San Marnan. And where else can you go if you if you don't want to send somebody to ADI? Where are the alternatives? Allen Hospital, Covenant Hospital, Sartori Hospital. Wherever they do angiograms. Well, you had 99 percent of your surgeries at Allen Hospital. Yes. Correct?	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q. A. Q.	they call you with the result, and that's been the case for years even as we speak and I don't like that. I like to be able to get a radiologist look at it, we'll talk about it right away. Okay. All right. And so I prefer ADI because that's the quality study I get and Cammoun or whoever is there, because when Cammoun is not there, he has somebody cover for him, they look at it, they get on the phone, they call me, I put it up, we talk about it. All right. And that's what happened here, Mr. McGrew went to ADI? That's what happened. It happens to all of my patients. Okay. So he goes off to ADI, gets that test done. When when do you get the results? That same day or is it the next day or what is the what's Most of the time the same day the same day it's done, within minutes or hours. Okay. Let me find the CT angiogram. So I have

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		EROMOSELE OTOAD	ESE, M	M.D.	5-8-18
		80			82
1	Α.	Okay.	1		just want to know what you how you can look
2	Q.	So let's say the report comes back. Do you	2		at these.
3		get Do you first talk with Dr. Cammoun or	3	Α.	Okay.
4		do you see the report or does it matter?	4	Q.	What is the significance of these numbers?
5	Α.	It varies. There have there have been times	5	Α.	He he he he's trying to tell us how he
6		when, you know, they don't have the report	6		came up with the degree of stenosis.
7		ready but they'll call me and say, ''I just did	7	Q.	Okay.
8		this CT angiogram and, you know, I have not	8	Α.	Based on these measurements.
9		dictated the report yet, but I understand you	9	Q.	So if you were in school back in the days when
10		want the report right away," and he taps me.	10		you took math class and the doctor and the
11		There are other times when the patient the	11		teacher told you to show your work, you might
12		report is sent so I I see the report. So it	12		come up with the answer, but then if you have
13		varies.	13		to show your work, you have to explain how you
14	Q.	All right. And I imagine there are situations	14		arrived at that?
15		where if there's something specifically bad on	15	A.	Yes.
16		the report that it's the kind of thing you need	16		Is that the idea here?
17		to let somebody know right away.	17		Yes.
18	Δ	Yes.	18		Okay. So Dr. Cammoun makes a statement. He
19		Okay.	19	<u> </u>	says, "This leads to approximately 65 percent
20		And – and he does that.	20		luminal stenosis compared with the distal
20		Did Do you recall in Mr. McGrew's case what	21		vessel," in parentheses, "postbulbar ICA."
21	ω.	happened, whether he ever Did he ever speak	22		What does that mean?
23		with Dr. Cammoun about this?	23	Δ	It's hard to tell without Okay, the the
23 24	۸	I don't recall.	24	73.	first thing there says, "Calcified and
		All right. So can you say one way or the other	24		noncalcified plaque"
_25	<u> </u>	Air right. So carryou say one way on the other	25		83
1			1	Δ	Okay.
1		whether you relied solely on his report or on	2		 "identified leading to a luminal stenosis at
2		conversations with him or you – you chose not	3	Λ.	the proximal ICA bulb, diameter 1.9
3		to rely on him at all? Can you tell us	4		millimeter."
4	^	anything about that?		0	Okay.
5		On him, him who? Him who? Dr. Cammoun.	5		That means he had measured the opening, there's
6	-			Λ.	a plaque, and the the lumen is narrowed from
7	А.	Oh. No. I rely on the history I took from the	7		this to that (indicating). So he measures the
8	~	patient, the CT angiogram.	8		opening.
9		Okay.	9	~	1 0
10		Right, to make the decision.	10		And what's what the 1.9 means.
11	Q.	Now, when you get the report, are you do you	11		That's what the 1.9.
12		know what you're looking at when you actually	12		That's the opening.
13		see the report? In other words, there are	13		Yes, that's the opening.
14		there are Let's find 6, for example. There	14		All right.
15		are statements along the bottom of that first	15	А.	Then he says the length of the narrowing is
16		page, numbers; for example 1.9, 8.8, 5.2, 7.9.	16		approximately 8 millimeters, so he measures how
17		Do you see those numbers?	17		long it is. Then he says the normal diameter
18		Yes, I see them.	18		of the postbulbar ICA is approximately 5.2, so
19		Do you know what those mean?	19		you now go past where the stenosis is and you
20		Yes, of course.	20		get a measurement there, supposedly the normal
21	Q.	Okay. That's what I'm that's what I'm	21		patent internal carotid, so that's 5.2. Then
22		trying to understand. I don't mean to I'm	22		it goes down to the distal common carotid. The
23		not trying to	23		carotid artery starts as one common carotid and
24		No, it's okay.	24		it divides into two. So the common, before it
25	Q.	make you think that you don't understand. I	25		divides, it measures 7.9.
					Page 80 to 83

		EROMOSELE OTOAD	ESE, N	1.D.	5-8-18
1	Q.	Okay. So here's, I think, what we should do.	1		call a bifurcation, where it splits off.
2		We've got a piece of paper here.	2	Α.	Yes.
3	Α.	Okay.	3	Q.	Okay. You have named each of the these
4		I've got a couple of pens, two different	4		sections
5		colors. What I'd like you to do is diagram the	5	Α.	Yes.
6		common carotid artery and the bifurcation where	6	Q.	correct? Then you have with a red pen put
7		it splits off into these two, and then if you	7		a sort of squiggly lines where you have
8		can, based either on your recollection of what	8		marked the location of the plaque. Correct?
9		you saw on the CT angiogram or what Dr. Cammoun	9	Α.	This one, yes (indicating).
10		has put in here or whatever combination, show	10	Q.	And then in between you – in very small
11		us the location, and I'm not going to hold you	11		writing you put 1.9, which would be matches
12		to the you know, to scale. I just want to	12		with what Dr. Cammoun puts in his CTA report.
13		get an idea of where the plaque and this	13		As the opening, yes.
14		noncalcified plaque was.	14	Q.	Correct. And then the 5.2 is above that,
15	А.	Okay.	15		that's the diameter of the
16	Q.	And then we can also use it to help us	16		Normal internal carotid artery.
17		understand the location of each of these	17		The place where there isn't plaque.
18		measurements.	18		Yes.
19	Α.	Okay.	19	Q.	Okay. And then below that, it's the 7.9 is
20	Q.	Fair enough? We're just going to be quiet.	20		the is the common carotid artery. That's
21		You don't It would be better if you just	21		the diameter there.
22		diagramed it first, then talk about it later.	22		Yes.
23	Α.	Okay. This will be ICA, ECA, CCA.	23	Q.	So is the location of the plaque just in this
24		MS. RINDEN: Don't talk. She has to	24		one these two areas that you have here?
25		record it.	25	Α.	Yes. It's just there (indicating).
		85		~	87
1	~	THE WITNESS: Oh, sorry.			One on each side of the ICA as
2	Q.	Then using the red pen, why don't you use the	2	А.	No, it's it's circum it's circumferential. This is through the diagram,
3	•	plaque show us where the plaque was.	3		so it's circumferential.
4		Approximately.	5	0	So it's just It's a ball almost.
5	Q.	Okay. Now, before you leave that and before we mark it, I'd like to take the blue pen	6		Yeah, it goes around (indicating).
6	۸	l'm sorry.			And it's got some length to it, I assume;
7		and like all good artists, you need to sign,	8	α.	right?
8 9	Q.	so if you could put - sign it.	9	Δ	These numbers, by the way, these are
10	Δ	l'il just put "Tony."	10	,	millimeters.
10	л.	MR. DIAZ: Thank you. All right. We'll	11	O	Right.
11 12		still be off the record.	12		It's
12		(An off-the-record discussion was held.)	13		important it's important that I put that
14		(Deposition Exhibit Number 24 was marked	14		there. That that's We're talking
15		for identification by the reporter.)	15		millimeters, not centimeters.
16	Q.	All right, Doctor, now we've marked this as	16	Q.	Yeah, because I was going to ask you about
17		Exhibit 24.	17		that. Dr. Halloran's outside film, he has
18	A.	Okay.	18		centimeters on there.
19		And all I want you to do at this point is	19	А.	Yeah, that's why I put it in there so
20		confirm that this is the diagram that you	20	Q.	Yeah, is that in your estimation, is that a
21		prepared while we were partly off the record.	21		typo or is that an outright mistake or what is
22	A.	It is.	22		it?
23	Q.	Okay. And I think what you have done is you	23	A.	Well, you have to talk to him. I saw that, and
24		have and let's make it clear. First of all,	24		I thought that's interesting because he - if
25		you have diagramed this area of what people	25		he's saying they're centimeters, then we're
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EROMOSELE OTOADESE, M.D. 5-8-18 90 88 natch -- the -- the wall actually is. For dealing with a whole different and we're 1 1 dealing with an aneurysm because the -- the 2 example, the true wall is like this 2 3 (indicating). So they take this number from common carotid that big is an aneurysm. 3 here to there. They -- So this would be this Q. Right. 4 4 number here minus 1.9 divided by that number. 5 A. But -- but then right below that he -- he 5 Q. So the formula is the same, it's just a interpreted the left internal carotid in 6 6 millimeters, so it's hard to say. Did he mean 7 different number that you're choosing for your 7 denominator, so to speak. centimeters, which changes the whole story 8 8 because then we are talking about aneurysm. So 9 A. Yes. 9 Q. Okay. I don't know. He will have to tell you. 10 10 A. And then there's the -- the common carotid Q. Sure, Lunderstand, But -- but what we're 11 11 matter, which takes -- that takes 7.9 minus 1.9 really talking about is millimeters in this 12 12 divided by 7.9, and that's important because area, right? 13 13 depending on where you are, the degree of A. Yeah. But it's important because if it is 14 14 stenosis or what equation you're using is going centimeters -- If you said the -- the carotid 15 15 to be different. The NASCET -- sorry, the -artery's this instead of that (indicating), 16 16 the European one, the ECST, overestimates the 17 those numbers become important because in the 17 stenosis. interpretation, Cammoun has the opening as 1.9 18 18 For example, a NASCET stenosis of 30 millimeters. Halloran has 3.2 centimeters. 19 19 percent is the same as ECST stenosis of 65 20 20 Q. Sure. 21 percent. So 40 percent NASCET is 70 percent A. So is he looking at this artery like this? 21 Q. Yeah, we're talking at that -- at that point 22 ECST, you know. So when it gets to higher 22 stenosis, like at 90 percent, then they come 23 we'd be apples and oranges. 23 closer because NASCET of 90 percent is the same 24 24 A. Yes Q. Agreed? Yeah, I understand. So in terms of 25 as ECST of 97 percent, so when you get there, 25 91 89 it's closer there, I guess to be more accurate. these numbers, do you then do something with 1 1 these numbers? 2 So it all depends. 2 A. Yeah. That's how I came up with -- with his 3 Q. And what -- what does it look like to you that 3 Dr. Cammoun used in his report? numbers. There are -- there are three 4 4 different ways you can use these numbers. 5 A. They both used the same. I looked at both and 5 they used the NASCET. Q. Okay. Let's go through each of them then. 6 6 Q. When you say "both," meaning --A. One of them is -- is the so-called NASCET. 7 7 A. Cammoun and Halloran. NASCET, N A S C E T. That stands for North 8 8 9 American Symptomatic Carotid Endarterectomy 9 Q. Thank you. A. The difference is the -- the diameter they got. Trial. The measurements -- No, I'll just use 10 10 While Halloran says the open lumen where it's 11 this. 11 12 the most stenotic is 3.2 and Cammoun says it's MS, RINDEN: Pen? 12 A. This one. If you use the NASCET criteria, it 13 1.9. 13 Q. Okay. says to determine the -- the stenosis, you have 14 14 A. So those are the kind of things that -to -- you take the 5.2 minus 1.9 divided by 5.2 15 15 Q. So when it comes to then you getting this 16 times 100. 16 17 report ---Q. Okay. 17 A. Yeah. A. Okay. The European Carotid Surgery Trial, it's 18 18 Q. -- do you rely exclusively on Dr. Cammoun's called the EC -- ECST, they don't use that. 19 19 findings or do you then look at them -- at the They do it differently. They take the 1.9, 20 20 divided by the size of the bulb, which is 21 CTA yourself and come up with your own 21 assessment? the -- they estimate where the actual lumen 22 22 starts, where the -- like the edge, this edge 23 A. I put everything together. 23 here. They use that instead of using what's 24 Q. Okay. 24 inside. They -- they estimate where the 25 A. From the history I obtained, it's a classic 25

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EROMOSELE OTOADESE, M.D. 5-8-18 92 94 amaurosis fugax and it's symptomatic. And from radiologist's final report. I am just looking 1 1 at it and saying this is 70 percent, but I'm the CTA, it is -- he says it's 65 percent, 2 2 Cammoun. This was before Halloran even got 3 not going to act on that 70 percent if the З radiologist's report doesn't agree. involved. 4 4 Q. Well, the radiologist says it's 65 percent. Is Q. Right. 5 5 that a significant difference? 6 A. So, yes, the CTA helps me with my decision-6 7 making because if Cammoun's reading comes back 7 A. Not in my book. and it says it's 20 percent or 30 percent, it Q. Okay. What -- what is the sort of 8 8 9 will make me think more -- think twice before I 9 recognized -- For a symptomatic patient, take patient to surgery. 10 what's the recognized percentage of stenosis 10 necessary to justify surgery where the surgery Q. Sure. And then if -- I had a question, it 11 11 will have greater success than the risk just kind of went (indicating audibly). 12 12 associated with that surgery? 13 A. It will come again. 13 MS. RINDEN: I'm going to object to the Q. It's okay. Let me think back because I think 14 14 form. Vague as to "recognized." Recognized by I'll get it back here. Well, maybe I won't get 15 15 16 who? it back, we'll see. 16 MR. DIAZ: That's why I'm asking him. Now, in terms of your review, so when 17 17 you're looking at the CTA, do you do your own 18 MS. RINDEN: You can -- Well, I don't 18 think the question defines it. I think it's measurements as well? In other words, do you 19 19 vague. That's my objection. come up with your own work, or do you only come 20 20 up with a final number? 21 You can answer if you can. 21 MR. WEILEIN: I'm going to join in the A. No, I don't do measurements. 22 22 objection. It's not clear, recommendation by Q. Okay. 23 23 radiologist, by vascular surgeons, or who. A. I'm a surgeon. I look at it, I say, "Oh, 24 24 that's" -- "that's at least 70 percent. Look 25 MS. RINDEN: Right. 25 95 93 MR. DIAZ: All right, let me withdraw that at that thing. It's irregular and it's got a 1 1 big chunk of calcium there and it's at least 70 2 and ask it. 2 Q. Doctor, do you -- do you look at -- do you rely percent, but we'll wait and see what the 3 3 upon any particular recommendations, radiologists say," because the radiologists 4 4 5 have special -- special instruments they use. 5 guidelines, anything you want to use from the It's on a computer-based, so they get better 6 literature or from research that you've done to 6 guide you in terms of deciding "I'm going to do measurement than I can get just looking at it. 7 7 surgery at 65 percent," "at 70 percent," at Q. Okay. So let's say you now have 65 percent 8 8 some other figure? 9 from Dr. Cammoun's report. You in your, I 9 A. The guidelines is 50 percent for symptomatic think, notes thought it was 70 percent. Why 10 10 patients. did -- Where did you come up with 70 percent? 11 11 A. From what I just said. I look at it, I say, 12 Q. Fifty percent, okay. And the guidelines that 12 you're using are what? Which ones? "Oh, this is 70 percent." I'm eyeballing it. 13 13 Q. Just the eyeball test. 14 A. All the guidelines. The Society of Vascular 14 Surgery guidelines, any guidelines you want to A. Yeah. 15 15 Q. Okay. And who -- who recognizes the eyeball look at. Fifty percent are symptomatic. 16 16 Q. All right. Symptomatic -- But it has to be test as the method of - of just determining 17 17 symptomatic. surgery for ---18 18 A. Fifty percent. MS, RINDEN: Hold on. 19 19 Q. All right. All right. Okay. Now, so if you Q. - this condition? 20 20 21 MS. RINDEN: Hold on a second. I'm going 21 relied solely on -- let's say you did -- this to object to the form. It's argumentative. 22 is hypothetical. If you relied solely on 22 Dr. Cammoun being correct that it's 65 percent, You can answer if you understand the 23 23 24 that in your estimation is sufficient to auestion. 24 A. Yeah. Yeah. Nobody. That's why I rely on the 25 perform surgery on this patient, this 25

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1		symptomatic patient.	1		MR. DIAZ: Sure, Let me know when
2	Α.	Yes.	2		everybody's ready.
3		Okay. Now, what if he's not symptomatic? What	3		MS. RINDEN: You're in response to Request
4		if you have an asymptomatic? Do the numbers	4		for Admission Number 12?
5		change or is it essentially the same?	5		MR. DIAZ: Correct.
6	Α.	Sixty percent for asymptomatic.	6		MS. RINDEN: All right.
7	Q.	Okay. So now, at 65 percent I'm going to	7	Q.	You say the following: You say, "While
8		use 65 percent because that's what	8		Dr. Otoadese believes his recommendation to
9		Dr. Cammoun's got – plus he's symptomatic, is	9		Mr. McGrew would have been a factor in
10		surgery the only option for this patient?	10		Mr. McGrew's decision to have the
11		Is the better option.	11		endarterectomy, the risks of not having surgery
12	Q.	So Which would suggest that there's other	12		were also made known to Mr. McGrew."
13		options. What are the other options?	13	-	That's correct.
14	Α.	Well, that's that's controversial. For	14	Q.	All right. So what other risks are you talking
15		the the the main controversy is with	15		about? What are the what are the risks of
16		asymptomatic patients. With symptomatic	16		not doing surgery?
17		patients, revascularization is pretty much the	17		Stroke.
18		option; but with asymptomatic patient, yeah,	18	Q.	And that is Is that risk regardless of
19		you can make a case for best medical therapy;	19		whether you do statins and other medications?
20		you know, statins, aggressive treatment of	20	Α.	I don't know that. I did not discuss statin
21	~	hypertension and other things for asymptomatic.	21	~	and other medications.
22		All right.	22		I know. That's what I'm asking.
23		But with symptomatic, no. When you met with the McGrews to discuss your	23 24	А.	I wasn't comparing just statin and medication. Just risks of not doing surgery versus doing
24 25	Q.	recommendation, did you talk about alternative	24		surgery.
25		recommendation, did you tak about alternative	123		Surgery.
		97	1		99
1		97 recommendations aside from surgery? Did you	1	0.	99 Right
1 2		recommendations aside from surgery? Did you	1		Right.
2		recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery.		Α.	Right. Yes.
		recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" "We could try statins and"	2	Α.	Right. Yes. So if you choose not to do So let's say the
2		recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" "We could try statins and" "and better treatment of your hypertension," or	2 3	Α.	Right. Yes.
2 3 4		recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" "We could try statins and" "and better treatment of your hypertension," or whatever other things were available? Did you	2 3 4	Α.	Right. Yes. So if you choose not to do So let's say the patient says to you, "You know, Doc, I
2 3 4 5	А.	recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" "We could try statins and" "and better treatment of your hypertension," or	2 3 4 5	Α.	Right. Yes. So if you choose not to do So let's say the patient says to you, "You know, Doc, I appreciate you telling me that I should have
2 3 4 5 6		recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" "We could try statins and" "and better treatment of your hypertension," or whatever other things were available? Did you discuss that with the family? No.	2 3 4 5 6	A. Q.	Right. Yes. So if you choose not to do So let's say the patient says to you, "You know, Doc, I appreciate you telling me that I should have surgery but, you know, I just don't want to do
2 3 4 5 6 7		recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" "We could try statins and" "and better treatment of your hypertension," or whatever other things were available? Did you discuss that with the family?	2 3 4 5 6 7	A. Q. A.	Right. Yes. So if you choose not to do So let's say the patient says to you, "You know, Doc, I appreciate you telling me that I should have surgery but, you know, I just don't want to do that."
2 3 4 5 6 7 8	Q.	recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" "We could try statins and" "and better treatment of your hypertension," or whatever other things were available? Did you discuss that with the family? No. Your viewpoint is, "This is the only treatment	2 3 4 5 6 7 8	A. Q. A.	Right. Yes. So if you choose not to do So let's say the patient says to you, "You know, Doc, I appreciate you telling me that I should have surgery but, you know, I just don't want to do that." Yes, that's an option.
2 3 4 5 6 7 8 9	Q.	recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" "We could try statins and" "and better treatment of your hypertension," or whatever other things were available? Did you discuss that with the family? No. Your viewpoint is, "This is the only treatment option I'm going to offer."	2 3 4 5 6 7 8 9	A. Q. A.	Right. Yes. So if you choose not to do So let's say the patient says to you, "You know, Doc, I appreciate you telling me that I should have surgery but, you know, I just don't want to do that." Yes, that's an option. And you say to him, "Well, you understand if
2 3 4 5 6 7 8 9 10	Q.	recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" "We could try statins and" "and better treatment of your hypertension," or whatever other things were available? Did you discuss that with the family? No. Your viewpoint is, "This is the only treatment option I'm going to offer." He's symptomatic and Yeah, his carotid	2 3 4 5 6 7 8 9 10	А. Q. Q. А.	Right. Yes. So if you choose not to do So let's say the patient says to you, "You know, Doc, I appreciate you telling me that I should have surgery but, you know, I just don't want to do that." Yes, that's an option. And you say to him, "Well, you understand if you don't do surgery, bad things can happen to you, which would include a stroke." Yes.
2 3 4 5 6 7 8 9 10 11	Q. A. Q.	recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" "We could try statins and" "and better treatment of your hypertension," or whatever other things were available? Did you discuss that with the family? No. Your viewpoint is, "This is the only treatment option I'm going to offer." He's symptomatic and Yeah, his carotid endarterectomy or stenting, those are the things that I discussed with them. All right.	2 3 4 5 6 7 8 9 10 11	А. Q. Q. А.	Right. Yes. So if you choose not to do So let's say the patient says to you, "You know, Doc, I appreciate you telling me that I should have surgery but, you know, I just don't want to do that." Yes, that's an option. And you say to him, "Well, you understand if you don't do surgery, bad things can happen to you, which would include a stroke." Yes. Okay. And the patient then says, "What kind of
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A.	recommendations aside from surgery? Did you say, "We don't necessarily have to do surgery. We could do" "We could try statins and" "and better treatment of your hypertension," or whatever other things were available? Did you discuss that with the family? No. Your viewpoint is, "This is the only treatment option I'm going to offer." He's symptomatic and Yeah, his carotid endarterectomy or stenting, those are the things that I discussed with them. All right. But I I I discussed the fact that if he does not want surgery, it's okay, you know. But I didn't say "best medical therapy." Yeah. That was one of the things that you There was some mention made of that, what you just said. I'm going to find the reference to it. In one of your In answer to one of the discovery requests, it's a request for admission, you say this is request Number 12.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	A. Q. A. Q. A. Q. A. Q. A.	Right. Yes. So if you choose not to do So let's say the patient says to you, "You know, Doc, I appreciate you telling me that I should have surgery but, you know, I just don't want to do that." Yes, that's an option. And you say to him, "Well, you understand if you don't do surgery, bad things can happen to you, which would include a stroke." Yes. Okay. And the patient then says, "What kind of risk are we talking about? How likely is it going to be? When is it going to be?" that kind of a thing. What do you tell them? Well, to put numbers on it, the risks of a stroke, fatal stroke fatal or nonfatal stroke is about 20 percent in two years. Okay. For a symptomatic amaurosis fugax. Right. All right. But in this case when you would have told them this risk of 20 percent

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1		not doing it?	1		encompasses whatever time occurs between the
2	Α	I didn't say 20 percent but I said the risk of	2		time of decision that we should do surgery and
3	,	stroke is high.	3		the and the time of actually doing surgery.
4	Q	Sure. Did you Was that In your mind	4		That's part of that risk. Right?
5		when you make that statement about 20 percent	5		MS. RINDEN: Object. Vague.
6		in two years, is that assuming that there is no	6		You can answer if you can.
7		treatment done on the patient?	7	А.	I don't know.
8	A.	Yeah, that's without surgery. Just continuing	8	Q.	Well, let me give an example Let me not
9		as	9		give an example. Let's talk specifically here.
10	Q.	Yeah, it's different though. I'm not asking	10	Α.	Okay.
11		MS. RINDEN: Let him Hold on. You've	11	Q.	When did you recommend surgery to Mr. McGrew?
12		got to let him finish. I want him to get his	12	Α.	When he came for the second visit to review the
13		answer out.	13		CTA.
14	Q.	Go ahead.	14	Q,	All right. So that is when? All right. I'm
15	Α.	Yes, because again, like I said earlier, I did	15		looking at Exhibit 7. Now, Exhibit 7, this
16		not discuss best medical management because	16		appears to be And this is confusing to me.
17		that's that becomes a factor in asymptomatic	17	Α.	Okay.
18		patients, so this is two different things.	18	Q.	Okay? And so you have to help me here.
19	Q.	I understand. If if the patient if	19		There's a date that says "Office Visit," Date:
20		you if the patient says, "Doc, I don't want	20		August 28, 2014. Then below it there's a "DOS:
21		to do surgery. What can you offer me?" You	21		8-20-2014." Do you see that?
22		would say, "I can offer you medical management,	22	Α.	Yeah.
23		meaning medications, but you have to understand	23	Q.	Which which date is it?
24		there's risk associated with just doing that."	24		The DOS is the date of service.
_25		Correct?	25	Q.	All right. And this is where you talk about
		101			103
1		Yes.	1	•	that you see that it's 70 percent stenosis.
2	Q.	And if you do that, if you do medical	2		Yes.
3		management, does the risk, that 20 percent, does that change in some way? Does it go down	3		And is that 70 percent based on your own Based on mine, yes.
4 5		to 10 percent or 5 percent or does it just stay	5		Okay. As opposed to you misstating, for
6		at 20?	6	ч.	
7	Δ				· · · · ·
8	<i>/</i> \ .				example, that it was actually 65 percent on the
	Ο	Nobody knows that for symptomatic patients, no.	7	А	example, that it was actually 65 percent on the report. Do you understand the difference?
q		Nobody knows that for symptomatic patients, no. Do you assume that it will help some?	7 8	A.	example, that it was actually 65 percent on the report. Do you understand the difference? I don't think that's a difference, in my view,
9 10		Nobody knows that for symptomatic patients, no. Do you assume that it will help some? You could assume. It's no no Yeah,	7 8 9		example, that it was actually 65 percent on the report. Do you understand the difference? I don't think that's a difference, in my view, between 65 and 70 percent.
10		Nobody knows that for symptomatic patients, no. Do you assume that it will help some? You could assume. It's no no Yeah, that's an assumption, but there are no studies	7 8 9 10		example, that it was actually 65 percent on the report. Do you understand the difference? I don't think that's a difference, in my view, between 65 and 70 percent. I understand. All I'm trying to figure out is
10 11	A.	Nobody knows that for symptomatic patients, no. Do you assume that it will help some? You could assume. It's no no Yeah, that's an assumption, but there are no studies that can support either way.	7 8 9 10 11		example, that it was actually 65 percent on the report. Do you understand the difference? I don't think that's a difference, in my view, between 65 and 70 percent. I understand. All I'm trying to figure out is when you put 70 percent in this document, are
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10 11 12 13 14 15 16 17 18 19 20 21 22 23	А. Q. А. Q.	Nobody knows that for symptomatic patients, no. Do you assume that it will help some? You could assume. It's no no Yeah, that's an assumption, but there are no studies that can support either way. Okay. All right. Now, patient now says to you, "All right, Doctor, you want me to do surgery. I'm going to go ahead and do it. When should we do it?" What do you tell them? You know, sooner than later. All right. I mean, "Should I be back here tomorrow? Should I go home tonight?" What what's It's not emergent so we don't have to do it today, but we should do it sooner than later. It's not something I don't recommend putting it off with your symptoms because the	7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A.	example, that it was actually 65 percent on the report. Do you understand the difference? I don't think that's a difference, in my view, between 65 and 70 percent. I understand. All I'm trying to figure out is when you put 70 percent in this document, are you is it that you thought it was 70 percent on the CTA, or is it your own assessment that "Regardless of what Dr. Cammoun says, I think it's 70 percent"? Yeah, that's my own eyeballing it, say this this 70 percent stenosis, yes. Gotcha. Okay. "The patient has not reported recurrent symptoms since his last office visit last week." That's true. Okay. So and then it says under Plan, "Based on his symptoms and the findings of the CTA, I

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		104			106
1		stent.	1	~	Cammoun.
2		Correct.	2		So let's talk about Dr. Halloran's review.
3	Q.	Okay. And then you say, "In the end patient	3		Okay.
4		has elected the CEA." And then you talk to him	4	Q.	Do do you think Dr. Halloran is qualified to
5		about You describe to him the procedure and	5		comment on the CTA?
6		answered any questions that he might have.	6		Yes. I John's a good radiologist, yes.
7		Correct.	7	Q.	Okay. Now, obviously we've noticed this
8	Q.	Okay. So now on August 20th, here's what I	8		centimeters/millimeters thing. Let's assume
9		want to know: If the patient says, "When?"	9		we're talking about apples and apples and not
10		when should you do the surgery?	10		apples and oranges.
11	Α.	Yeah, I sent them from there to go to my	11		Okay.
12		office my secretary and she'll schedule it.	12	Q.	He comes up with a different essentially
13	Q.	And what I'm asking you is during this time	13		opening, as you described it, an area where
14		that you're waiting from from telling him	14		blood can still pass through, so that opening
15		that you should do surgery until the time that	15		is bigger. If that is correct, then would you
16		actually surgery is actually done, is this	16		agree that the number cannot be 65 or 70
17		man at risk, then, under your assessment? Is	17		percent?
18		he at risk for a stroke?	18	Α.	Again, you're asking me to speculate, you know.
19	Α.	Yes. He's always at risk for stroke from	19		I don't I I disagree that it's 32
20		symptomatic amaurosis fugax.	20		percent from his calculation. Strongly
21	Q.	Okay. All right. Now, Dr. Bekavac saw this	21		disagree.
22		patient a few weeks after the surgery and	22	Q.	Have you gone back since Since you did the
23		prepared a report. I believe, if I'm not	23		recommendation and eyeballed it, have you gone
24		mistaken, I provided you with a copy of that	24		back to look at the CTA?
25		before the lawsuit was ever filed. Did you get	25		Nultiple times
			25	Α.	Multiple times.
		105	25		107
1		a chance to see that?	1		107 And do you think that Does that does
1 2		a chance to see that? Yes, I saw it.	1 2	Q.	107 And do you think that Does that does that change your viewpoint at all?
1	Q.	105 a chance to see that? Yes, I saw it. Okay. Have you seen it lately?	1 2 3	Q. A.	107 And do you think that Does that does that change your viewpoint at all? Not at all.
1 2 3 4	Q. A.	105 a chance to see that? Yes, I saw it. Okay. Have you seen it lately? Yes.	1 2 3 4	Q. A.	107 And do you think that Does that does that change your viewpoint at all? Not at all. All right. And do you I know you don't do
1 2 3 4 5	Q. A.	105 a chance to see that? Yes, I saw it. Okay. Have you seen it lately? Yes. Okay. I'm happy to pull it out if you want to	1 2 3 4 5	Q. A.	107 And do you think that Does that does that change your viewpoint at all? Not at all. All right. And do you I know you don't do this as part of your assessment, but have you
1 2 3 4 5 6	Q. A.	105 a chance to see that? Yes, I saw it. Okay. Have you seen it lately? Yes. Okay. I'm happy to pull it out if you want to talk about it, but he has significant	1 2 3 4 5 6	Q. A.	107 And do you think that Does that does that change your viewpoint at all? Not at all. All right. And do you I know you don't do this as part of your assessment, but have you gone to look at the measurement technique
1 2 3 4 5 6 7	Q. A.	105 a chance to see that? Yes, I saw it. Okay. Have you seen it lately? Yes. Okay. I'm happy to pull it out if you want to talk about it, but he has significant disagreement with you about, one, whether the	1 2 3 4 5 6 7	Q. A. Q.	107 And do you think that Does that does that change your viewpoint at all? Not at all. All right. And do you I know you don't do this as part of your assessment, but have you gone to look at the measurement technique that's available on this on this?
1 2 3 4 5 6 7 8	Q. A.	105 a chance to see that? Yes, I saw it. Okay. Have you seen it lately? Yes. Okay. I'm happy to pull it out if you want to talk about it, but he has significant disagreement with you about, one, whether the CTA shows this 65 or 70 percent number. I	1 2 3 4 5 6 7 8	Q. A. Q.	107 And do you think that Does that does that change your viewpoint at all? Not at all. All right. And do you I know you don't do this as part of your assessment, but have you gone to look at the measurement technique that's available on this on this? I've played with the image, turn it around,
1 2 3 4 5 6 7 8 9	Q. A.	105 a chance to see that? Yes, I saw it. Okay. Have you seen it lately? Yes. Okay. I'm happy to pull it out if you want to talk about it, but he has significant disagreement with you about, one, whether the CTA shows this 65 or 70 percent number. I think his I recall, and this is off the top	1 2 3 4 5 6 7 8 9	Q. A. Q.	107 And do you think that Does that does that change your viewpoint at all? Not at all. All right. And do you I know you don't do this as part of your assessment, but have you gone to look at the measurement technique that's available on this on this? I've played with the image, turn it around, look at it, see if there's any way, you know, I
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1 2 3 4 5 6 7 8 9 10 11	Q. A. Q.	105 a chance to see that? Yes, I saw it. Okay. Have you seen it lately? Yes. Okay. I'm happy to pull it out if you want to talk about it, but he has significant disagreement with you about, one, whether the CTA shows this 65 or 70 percent number. I think his I recall, and this is off the top of my head, something around 40 percent, something less than that	1 2 3 4 5 6 7 8 9 10 11	Q. A. Q. A.	107 And do you think that Does that does that change your viewpoint at all? Not at all. All right. And do you I know you don't do this as part of your assessment, but have you gone to look at the measurement technique that's available on this on this? I've played with the image, turn it around, look at it, see if there's any way, you know, I can come up with anything that lower. No. Okay.
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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A. Q.	105 a chance to see that? Yes, I saw it. Okay. Have you seen it lately? Yes. Okay. I'm happy to pull it out if you want to talk about it, but he has significant disagreement with you about, one, whether the CTA shows this 65 or 70 percent number. I think his I recall, and this is off the top of my head, something around 40 percent, something less than that Okay. maybe. And believes that the surgery was unnecessary. Obviously you disagree because you made a recommendation for surgery. So tell me what's wrong with Dr. Bekavac's assessment. I don't know how he came to that conclusion, so I can't tell you, but I disagree with it because it's not 40 percent stenosis. Have you ever sat down and talked to him or called him on the phone and said, "What are you doing putting this in writing?" or anything like that?	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Q. A. Q. A.	107 And do you think that Does that does that change your viewpoint at all? Not at all. All right. And do you I know you don't do this as part of your assessment, but have you gone to look at the measurement technique that's available on this on this? I've played with the image, turn it around, look at it, see if there's any way, you know, I can come up with anything that lower. No. Okay. It The problem with You know, I don't know how much of all this I should be saying, but with imaging, you know, carotid endo carotid surgery is probably most common surgery that vascular surgeons do. We've been doing them since the '50s, and it's probably the most studied procedure. But after all these years, there's still no agreement. There's no agreement on the best how to decide what the preop imaging what's the best way of imaging. There's no agreement on that. There are there are there are

		EROMOSELE OTOADI 108	ESE, N	1.D.	5-8-18
1		groups that even would do surgery just with	1		MS. RINDEN: Okay.
1 2		without imaging without CT or MRA, just with	2		MR. DIAZ: So I want to just check.
2		ultrasound. So there's no there's no	3		THE VIDEOGRAPHER: Going off the record.
		agreement on that. There's no agreement on the	4		The time is 11:57 a.m.
4		-	5		(A brief recess was taken.)
5		criteria for interpreting the imaging studies	6		THE VIDEOGRAPHER: We're on the record at
6		even when you decide what imaging studies. You can have five radiologists in this	7		12:12 p.m.
7 8		room and give them the same image. They'll	8	0	All right. Doctor, I have a few more questions
		come up with different numbers, guaranteed.	9	ω.	about Exhibit 6.
9 10		True for surgeons too. And there's also no	10	Δ	Okay.
10		agreement on how you select whose patient to	10		Let's assume It's a hypothetical. Let's
11		offer surgery to either. So it's it's	12	ω.	assume that Dr. Cammoun, instead of putting
13		controversial. It's and it's it's going	13		down "leads to approximately 65 percent
15 14		to be like that. I have examples that I can	14		stenosis" says, "35, 40 percent stenosis." And
14 15		show you of patients just like Mr. McGrew who	15		you get the CTA. Are you going to look at the
15 16		have had four radiology three radiologists	16		CTA when he says, "35 to 40 percent"?
10		and including Halloran and Bekavac who have	17	Δ	Yes. Of course I look at it.
18		given different completely different	18		Okay. So now you look at it and you eyeball it
19		interpretations.	19	· .	and you think, "This is 70 percent. What's he
20	0	And	20		talking about 35 or 40 percent?" What do you
21		In the end I made the decision what to do with	21		do in that instance?
22		him.	22	A.	That has happened a lot and I pick up the
23	Q.	Are you aware of of surgeons that would take	23		phone, I call him, and I say, "Are we looking
24		a patient like Mr. McGrew, symptomatic in	24		at the same thing because I'm seeing 60"
25		your view symptomatic and 65 percent, for	25		"I'm seeing at least 70 percent here. That
•••••		109			111
1		example, and say, "Not yet. We're going to	1		thing is ugly," you know. And he would say
2		wait to see if it gets to 70 percent or more."	2		typically, "I'm looking at it, too, and however
3		And are you aware of people that will do that?	3		I look at it, I can't get more than 30 percent.
4	Α.	No. Not for symptomatic patients, no.	4		Well, tell me what you're looking at is
5	Q.	All right.	5		probably because of the plaque. You got a
6	Α.	Asymptomatic, yes.	6		heavy plaque there, but I really don't see
7	Q.	Okay. Did you share this this discussion	7		anything more than 30 percent."
8		you just had with us about that's	8		That's the kind of conversation we have,
9		controversial and that different people look at	9		you know, and and I'm obviously content with
10		different things, did you discuss that at all	10		it because he said, "I" "I've rotated it,
11		with the patient and say, "Hey, you know, you	11		I've looked at it. No, it's not more than
12		might want to get a second opinion. Let's get	12		that." I say, "All right." That's it.
13		two people on this"?	13		But I've also seen the the opposite
14	А.	Not with Mr. McGrew, I don't recollect, but I	14		where even Cammoun and Halloran and Bekavac,
15		do that quite frequently with with patients.	15		they they've made mistakes too. You know,
16		I'd say, "You don't have to have your surgery	16		I've had – I just had a case where it was a
17		here. You can look at a second opinion, you	17		leg thing, you know. Patient is complaining of
18		know. As a surgeon, this is what I think, but	18		left leg pain. You know, left leg is what is
19		you don't have to do this. You don't have to	19		bothering him all the time.
20		do it here." I do that. I don't remember if I	20		We did a CT angiogram and Cammoun read it,
21		did that with him.	21		and he sent it back and it's normal. The
22		All right.	22		vascularization on the left is completely
23	А.	But I do.	23		normal, and the right had some disease in
24		MR. DIAZ: Okay. Let's let's take a	24		there. But I put up the picture and I could
25		break. I'm almost – I think I'm almost done.	25		see right there that the external iliac artery
					Page 108 to 111

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4		is you know, by my eyeball is at least 80	1	Δ	That's that's known. Anybody who does this
1		,	2	Λ.	work will tell you that. Yes.
2		percent.		0	Okay. Were you aware Remember when I sent
3		I picked up the phone, I called him and	3	Q.	you a letter right at the beginning, and I
4		said, "You know, why don't you take a look at	4		
5		it again because I have" "this is what I'm	5		provided you with a copy of what might be a
6		looking at and I see there's a stenosis there,	6		lawsuit and said, "Let me know if" you know,
7		the origin of the left external iliac artery."	7		"You talk me out of this," essentially. I have
8		And he put it up. He says, "You know, you're	8		a copy of it here somewhere if you want me to
9		right." You know. "I'll send an addendum."	9		show it to you. Do you Because I asked you
10		So he corrected it. It was, you know, 75	10		about that earlier, do you remember?
11		percent stenosis and, you know, I can have that	11	Α.	I remember a letter. I've I've got
12		conversation with him and that's how we work,	12		MS. RINDEN: Hold
13		and I couldn't have that with somebody at	13	Q.	Let me make it easier. Let me find it.
14		Visual Radiology in another country or	14		MS. RINDEN: Well, hold on a minute. So
15		something. So, yes, it's	15		now you're wanting to ask him about a
16	Q.	Okay. But I get from your answer that you're	16		settlement demand you made threatening a
17		ultimately it sounds like you're ultimately	17		lawsuit if he didn't –
18		relying upon what the radiologist is telling	18		MR. DIAZ: No.
19		you as to what he or she sees with regard to	19		MS. RINDEN: either provide you with
20		percentages.	20		some reason that you're wrong or give you some
21		MR. WEILEIN: Objection. That's a	21		money. Is that what we're talking about here?
22		misstatement of his testimony.	22		MR. DIAZ: No. Not a settlement demand.
23	Α.	Yes. Combined with the history, everything put	23	Q.	Here's the here's the letter itself here.
24	,	together, yes.	24		MS, RINDEN: Hold on.
25	0	Okay.	25		MR. DIAZ: You get a copy.
		113	+		115
1	Δ	I have - I I have I've seen cases where	1		MS. RINDEN: Hang on, Tony. I want to
2	л.	the neurologists or radiologists estimate a	2		look at it first.
3		stenosis that's critical, and I did not operate	3		Well, you can read it and then we'll let
4		because from the history that the patient	4		him ask his question, make an objection to it.
		gives, putting things together in spite of them	5	Δ	Yes, I remember it.
5		calling it 80 percent, I did not operate. I	6		. Okay. And I think you indicated that you did
6		said, "You know, I just don't think they're	7	α.	not respond to that. Correct?
7		symptomatic from this."		Δ	I referred it to my attorney.
8	~		9	л.	MS. RINDEN: And we're not going to talk
9		All right.			about anything that we've discussed.
10		So	10		Attorney-client privilege, so
11	Q.	Second thing I want to ask you about, you made	11		MR. DIAZ: Yeah, I'm not and I'm not
12		mention earlier about guidelines that you rely	12		
13		on for symptomatic patients who have more than	13	~	asking about
14		50 percent stenosis as being surgical	14	Q.	I guess here's my question to you: Were you
15		candidates. Can you provide us with two or	15		aware that I did the same with Dr. Cammoun?
16		three documents that you	16		That I sent him exactly the same letter?
17	Α.	We can look them up. Sorry, I am speaking too	17		No.
18		soon. It is the Society of Vascular Surgery.	18	Q.	. Were you aware that Dr. Cammoun's lawyer
19		You can Google it, I mean.	19		responded? Were you aware of that? Have you
20		Okay.	20		ever seen that letter?
21		Yes, the Society of Vascular Surgery guideline.	21		MS. RINDEN: Hold on a second.
22	Q.	Okay. Anybody Any other guidelines that	22	Α.	. No.
23		you're relying on for your statement that you	23		MS. RINDEN: We can – I don't have that
24		can do surgery with a symptomatic patient where	24		with me. We've talked about the articles that
25		stenosis is 50 percent or greater?	25		Dr. Cammoun provided in this lawsuit through
					Page 112 to 115

		EROMOSELE OTOAD 116	ESE, I	ví.D.	5-8-18
1		George.	1		2014?
1 2		THE WITNESS: Yeah.	2	Δ	Oh, yes.
2		MS. RINDEN: That's what he's talking	3		Okay. Do you think it was after 2000, the year
3 4		about.	4	α.	2000?
4 5		THE WITNESS: Okay.	5		MR. WEILEIN: I'm going to object just
6		MS. RINDEN: So you have seen that, Tony.	6		because you're mixing apples and oranges. He's
7		THE WITNESS: Okay.	7		already said he only knows about vascular
8	0	All right. Well, you're aware that	8		surgery standards, he doesn't know about
9	α.	Dr. Cammoun's provided at least through his	9		radiology standards, so you're asking him to
10		lawyer provided articles	10		comment on things he's not qualified to comment
11	Α	Okay.	11		on.
12		in which the claim is that before you do	12	Ο.	I'm asking about this the guidelines you've
13	ω.	surgery on this patient, on Mr. McGrew, that	13	ч.	been talking about from this I think you
14		you need to get to 70 percent stenosis and that	14		said Society of
15		65 percent is not sufficient. Are you aware	15	A.	Society of Vascular Surgery.
16		that that's that was the position taken by	16		MR. WEILEIN: Right, which Dr. Cammoun is
17		Dr. Cammoun and his lawyer?	17		not a member of because he's a radiologist
18		MR. WEILEIN: And that's a misstatement of	18		MS. RINDEN: Hold on. We've got to
19		the position taken by Dr. Cammoun and his	19		MR. DIAZ: I'm not interested I
20		lawyer.	20		understand, George. I'm just I'm interested
21	Α.	I read the article and that was a 1991 article.	21		in asking him questions based on what he's
22		1991. And that was the the the original	22		testified to.
23		NASCET trial, yes. They did it on patients	23	Q.	So I'm trying to pin down when was when do
24		with stenosis greater than 70 percent, and it	24		you think that went into effect? What year, as
25		was beneficial.	25		best you can tell me?
	~	117			119
1		So	1	A.	I don't recollect but it's in this day and age,
2		So Since then	2	A.	I don't recollect but it's in this day and age, you can Google it. Your partner can look it up
2 3	A.	So Since then MS. RINDEN: Hold on.	2 3		I don't recollect but it's in this day and age, you can Google it. Your partner can look it up right now and tell you.
2 3 4	A. Q.	So Since then MS. RINDEN: Hold on. Sorry.	2 3 4	Q.	I don't recollect but it's in this day and age, you can Google it. Your partner can look it up right now and tell you. Okay.
2 3 4 5	A. Q.	So Since then MS. RINDEN: Hold on. Sorry. Since then the NASCET trial has included	2 3 4 5	Q.	I don't recollect but it's in this day and age, you can Google it. Your partner can look it up right now and tell you. Okay. The Society of Vascular Surgery guidelines for
2 3 4 5 6	A. Q.	So Since then MS. RINDEN: Hold on. Sorry. Since then the NASCET trial has included patients that have greater than 50 percent, and	2 3 4 5 6	Q. A.	I don't recollect but it's in this day and age, you can Google it. Your partner can look it up right now and tell you. Okay. The Society of Vascular Surgery guidelines for carotid endarterectomy.
2 3 4 5 6 7	A. Q.	So Since then MS. RINDEN: Hold on. Sorry. Since then the NASCET trial has included patients that have greater than 50 percent, and the conclusion is, yes, they have a benefit if	2 3 4 5 6 7	Q. A. Q.	I don't recollect but it's in this day and age, you can Google it. Your partner can look it up right now and tell you. Okay. The Society of Vascular Surgery guidelines for carotid endarterectomy. Okay.
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2 3 4 5 6 7 8 9	A. Q.	So Since then MS. RINDEN: Hold on. Sorry. Since then the NASCET trial has included patients that have greater than 50 percent, and the conclusion is, yes, they have a benefit if it's greater than 50 percent. The only time they don't get benefit is if it's less than 50	2 3 4 5 6 7	Q. A. Q. A.	I don't recollect but it's in this day and age, you can Google it. Your partner can look it up right now and tell you. Okay. The Society of Vascular Surgery guidelines for carotid endarterectomy. Okay. Symptomatic. All right.
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EROMOSELE OTOADESE, M.D. 5-8-18 122 120 if I did not send a specimen, I'll have no -ulcerated plaque, so that's what I meant by 1 1 2 no feet to stand on because this is what I took 2 "complex." It's not just a regular plaque out, and there is no way that the plaque -- the 3 that's calcium. It's got mixed things there. 3 It's -- it's irregular and ulcerated. That's 4 size of that plaque, if you put in the internal 4 carotid artery, you still have -- you have 70 important because the risks of embolization and 5 5 6 percent open. a stroke from the plague is very high when it's 6 7 Q. That's what I was going to ask you. 7 ulcerated and irregular. A. It's impossible. Q. The records indicate that you sent a surgical 8 8 Q. I'm sorry. That's what I was going to ask you 9 9 specimen or tissue to pathology for evaluation. is are you able to -- does the two-centimeter I'm going to hand you a pathology report. It's 10 10 found at Allen Hospital page 243. Doctor, can 11 wide, for example --11 12 A. Yes. you tell us first of all what specimen did you 12 Q. - that would be like 20 millimeters; right? 13 send in for a pathology evaluation? 13 A. That -- yeah, that's an inch. Two and a half A. It's the -- the plaque from the carotid artery 14 14 15 is an inch. surgery. 15 Q. How does that -- how does that tell us, if Q. So it was the plaque that you removed during 16 16 anything, about what it would have looked like 17 Mr. McGrew's surgery? 17 before it was removed? In other words, how A. Yes. 18 18 Q. And what -- what were the dimensions of that 19 much of a stenosis would there be? 19 A. Yes. It -- The pathologist will tell you. plaque that you removed during surgery, 20 20 21 When I take it out, I try to pull the whole according to the pathology report? 21 22 thing in one piece, so you could see the common A. Yeah, according to the report, it's four 22 centimeters long and two centimeters wide 23 carotid, the bifurcation, the plaque going into 23 24 the external, and the plaque going into the tubule of hard and rubbery, yellow-orange 74 25 internal, so the whole thing. So the 25 tissue. 123 121 Q. All right. And you mentioned earlier today pathologist can look at it and tell us if 1 1 2 the -- the -- the -- the morphology of the that you are not a radiologist but that you 2 look at your own imaging for your patients. Is plaque because morphology is very important. З 3 4 Q. Okay. But can you, based on this four-by-twothat right? Δ centimeter piece of pathology, tell us how that 5 5 A. I do, right. Q. Can you explain to the jury why you look at the converts to millimeters in terms of what might 6 6 have been stenotic or making it harder to pass imaging yourself for your patients? 7 7 8 blood through? A. So I understand what the radiologist is saying 8 A. You can make measurements. You can go back and 9 and how I can explain it better to the patient. 9 measure the -- the internal carotid, the common I usually show them the imaging. I show it to 10 10 carotid, and then see how this plaque will fit them, I point out what the report is saying, 11 11 in there and estimate, but -and we go from there, but I look at all of 12 12 Q. You didn't do that. 13 13 them A. No. MS. RINDEN: All right. Those are all the 14 14 guestions I have. 15 Q. And did you during surgery itself try to 15 16 measure the -- the width of the -- the open MR. WEILEIN: I have no questions. 16 REDIRECT EXAMINATION 17 artery once you were done? 17 A. I estimated it but not with calipers or BY MR. DIAZ: 18 18 Q. What's the significance of this four centimeter 19 anything, no. 19 20 Q. Okay. by two centimeter? 20 A. But I opened it, I looked. We -- we all talked 21 A. It's -- it's -- it's a good -- That's the 21 about it and so in every case, actually. plaque I took out because I send them off. 22 22 It's irregular, it's mixed, and it's ulcerated, 23 Q. Right. 23 A. "Wow, look at this. You know, it's almost which increases the risk quite a bit for a 24 24 25 occluded, and they're saying it's 50 percent." 25 stroke, embolization from the plaque. If I --Page 120 to 123

FROMOSELE OTOADESE, M.D. 5-8-18 126 124 1 We talk about it, you know, commonly. 1 57 percent stenotic. Dr. Bekavac saw it and MR. DIAZ: Okay. All right. I appreciate disagreed and --and said, "Oh, no, no, no. 2 2 It's 85 percent stenotic on the right and 75 3 your time. Thank you, sir. 3 percent stenotic on the left." THE WITNESS: I'd like to add -- It's 4 4 important -- Jennifer, maybe I should not talk So based on that, he sent -- he sent the 5 5 about it, this CD that I have. Want me to patient to me for surgery. Eighty-five percent 6 6 blocked, so I saw the patient. These mental mention it? 7 7 MS. RINDEN: Well, we've got HIPAA --status changes might be coming from the 8 8 HIPAA issues, so we can't be referencing carotid. And I saw the patient and wasn't 9 9 patient names. I think we'll wait on that. convinced that her symptoms are from the 10 10 THE WITNESS: Okay. Maybe a jury will see carotid, but I was -- this case was already on 11 11 12 my mind, this case -- Mr. McGrew's case, and I that. 12 MS. RINDEN: Yeah. We'll figure that out. 13 thought, okay, I'll do a little test here. 13 So I had Dr. Halloran look at the CD, look MR. DIAZ: All right. So -- so that I'm 14 14 at the same study, and Dr. Halloran read the clear, since this is my opportunity to talk to 15 15 same study that Dr. Bekavac had read and you ---16 16 MS. RINDEN: Yeah. said -- he called me and said, "Well, I" -- "I 17 17 don't" --- "I can't get it more than 68 percent MR. DIAZ: -- apparently you have a CD of 18 18 other patients? 19 stenotic on the right, 64 percent stenotic on 19 THE WITNESS: I wanted to show you an 20 the left." 20 example of how complicated this can be. I have 21 Okay. Then I said, all right. Let's do 21 an elderly patient who was sent to me by this with Cammoun, you know. He's a 22 22 radiologist. He's not aware of any of this. Dr. Bekavac. 23 23 MS. RINDEN: We'll just do it. 24 He's at ADI. So let's have him look at it too. 24 MR. DIAZ: Well, I don't want to violate Dr. Cammoun looks at it, and he says the right 25 25 125 127 is 55 percent stenotic, the left is 58 percent that patient's privacy. 1 1 stenotic. So here we are, you know. Two THE WITNESS: No name, no name. 2 2 MR. DIAZ: Without names. radiologists -- three radiologists, actually, 3 3 and a -- a neurologist with all this stuff. MS. RINDEN: Hold on. Let's just go off 4 4 5 Just was the 6th, two days ago, while the record for a second. 5 preparing for this deposition, I had another THE VIDEOGRAPHER: Going off the record. 6 6 radiologist, Dr. Halloran's partner, look at 7 The time is 12:29 p.m. 7 (An off-the-record discussion was held.) it, this same study, and we looked at it 8 8 THE VIDEOGRAPHER: We're on the record. together. He showed me how he was doing the 9 9 measurements and everything. He came up with It's 12:29 p.m. 10 10 THE WITNESS: Okay. This -- this patient 55 percent stenosis on the left and 50 percent 11 11 on the right. Okay. You have the dilemma. was sent to me by a neurologist, Dr. Bekavac, 12 12 for evaluation for -- this was in December for If I operated on that same patient based 13 13 on what Dr. Bekavac had recommended, and the carotid surgery. The patient -- the patient's 14 14 patient suffers a stroke, there will be a family complained that -- They took her to see 15 15 Dr. Bekavac because she was not acting right. lawsuit. There may be a lawsuit, and the 16 16 She was confused and wasn't walking right, like radiologists obviously will be expert witnesses 17 17 saying, "Why did you operate? It's 50 percent she was limping, and her speech wasn't very 18 18 clear and things like that. So they took her stenosis. It's not indicated." 19 19 to Bekavac, and he saw her and ordered a CT 20 If I did not operate on this patient, 20 angiogram of the carotid. which I have not yet -- I'm biting my fingers 21 21 The -- the report came back. The every day -- and the patient suffers a stroke, 22 22 Dr. Bekavac will be the expert witness saying, radiologist in Minnesota who read it said the 23 23 right side of the carotid artery was 50 percent 24 "What were you thinking? It's 85 percent 24 stenotic. The left-side internal carotid was stenotic here and 70 percent stenotic and you 25 25 Page 124 to 127

		EROMOSELE OTOADI	ESE, M.D.	5-8-18
1		128 didn't do surgery?" That's what we face, and	1	(Deposition concluded at 12:36 p.m.)
2		that's the difficulty in making the decision.	2	
3	Q.	(By Mr. Diaz, continuing) Okay. And this	3	
4		patient was symptomatic?	4	
5	A.	Right. Depends on how you say it. I told you	5	
6		what the family said, that she wasn't walking	6	
7		right and she was confused and her speech	7	
8		wasn't quite	8	
9	Q.	Mr. McGrew said he had transient loss	9	
10	Α.	l know so	10	
11	Q.	of vision. It's based on patient history.	11	
12	Α.	Well, yes, that's what I'm saying. That's what	12	
13		we face, so I have not operated on this	13	
14		patient. I just thought we'd just wait because	14	
15		my gut feeling is that she's not this is not	15	
16		what's causing her especially when we get	16	
17		this variation. You know, I'm thinking, okay,	17	
18		here we go again, you know.	18	
19		Okay.	19	
20	Α.	Hope Luckily, I don't have too many of	20	
21		these to to discuss, but it's a difficult	21	
22		and complex problem.	22	
23	Q.	And remind me, did you say that the Society of	23	
24		Vascular Surgeons guidelines are symptomatic	24	
25		plus 50 percent or greater or more than 50	25	131
		120		
		129		<u>CERTIFICATE</u>
1		percent?	2	I, the undersigned, a Certified Shorthand Reporter of the State of Iowa, do hereby
2		percent? Fifty percent or greater.	2 3	I, the undersigned, a Certified Shorthand
2 3	Q.	percent? Fifty percent or greater. Well, under that	2 3 4	I, the undersigned, a Certified Shorthand Reporter of the State of Iowa, do hereby certify that there came before me at the date, time and place hereinbefore indicated, the witness named on the caption sheet hereof, who
2 3 4	Q. A.	percent? Fifty percent or greater. Well, under that For symptomatic.	2 3 4 5	I, the undersigned, a Certified Shorthand Reporter of the State of Iowa, do hereby certify that there came before me at the date, time and place hereinbefore indicated, the witness named on the caption sheet hereof, who was by me duly sworn to testify to the truth of said witness's knowledge touching and
2 3 4 5	Q. A.	percent? Fifty percent or greater. Well, under that For symptomatic. Under that analysis, all of these people give	2 3 4 5	I, the undersigned, a Certified Shorthand Reporter of the State of Iowa, do hereby certify that there came before me at the date, time and place hereinbefore indicated, the witness named on the caption sheet hereof, who was by me duly sworn to testify to the truth of
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2 3 4 5 6 7	Q. A. Q.	percent? Fifty percent or greater. Well, under that For symptomatic. Under that analysis, all of these people give you the basis for surgery. Correct? Correct. Then why You know, that's what	2 3 4 5 6 7	I, the undersigned, a Certified Shorthand Reporter of the State of Iowa, do hereby certify that there came before me at the date, time and place hereinbefore indicated, the witness named on the caption sheet hereof, who was by me duly sworn to testify to the truth of said witness's knowledge touching and concerning the matters in controversy in this cause; that the witness was thereupon examined under oath, the examination taken down by me in shorthand, and later reduced to computer-aided transcription under my supervision and
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App. 91



September 26, 2014

RE: William McGrew

Ivo Bekavac, MD, PhD

Dept. of Neurology

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Mr. William McGrew comes in self-referral as well as his family for second opinion about stroke.

HISTORY OF PRESENT ILLNESS: According to the patient and his family on August 5, 2014 he had episode of visual problem, describes everything was greying on his eye lasting between one to two minutes. No associated weakness involving any part of his body. He was otherwise healthy except hypertension. He went to see Dr. Mauer, who send him to see Dr. Otoadese and CTA was done of the extracranial circulation on August 18, 2014. It was read by Dr. Cammoun, who felt there was right ICA stenosis around 65%. I did review personally and showed to the patient and his daughter and son and my opinion stenosis of right ICA is Subsequently Dr. Otoadese performed right carotid artery approximately 40%. endarterectomy on September 2, 2014. Prior to the surgery patient was asymptomatic. He was not taking aspirin when this event occurred and was just started a week or so before the surgery. Extensive records reviewed around 60 pages. After surgery he was doing great and then very next morning around 7:10 it was noticed by nurse as well as his daughter the patient was confused and had left facial droop. Dr. Almullahassani, a neurologist was called who ordered CTA which apparently showed right ICA occlusion. CTA was done at 11:05 and symptoms started around 7:10 a.m. MRI of the brain showed acute right M2 territory ischemic infarct and some changes involving basal ganglia involving territory of the lenticulostriate arteries. Dr. Almullahassani requested second endarterectomy and clot removal. Apparently Dr. Otoadese was not willing to do so, but then Dr. Almullahassani according to the patient's daughter asked for opinion by Dr. Karimi, a vascular surgeon at Covenant Medical Center was about to transfer the patient, then finally Dr. Otoadese came back and performed right endarterectomy between 3:00 to 3:30 p.m. After the surgery the patient had complete weakness on the left side. Prior to that family is not sure whether he had any weakness involving his left hand at all. Also became confused and eyes were looking to the right side. He has been essentially the same since the second surgery. Repeat MRI done following day did reveal very similar area of infarction according to my review essentially unchanged from previous one done day before. The patient has been on aspirin for stroke prophylaxis 325 mg a day. Since the surgery he has been also complaining of lower back pain on the left side without shooting distally. No imaging of the lumbosacral spine. He has been doing stroke rehabilitation. The patient wants to know exactly the reasoning behind surgery whether first surgery and second surgery was indicated.

REVIEW OF SYMPTOMS: Complete review of (14) systems and complete past medical and social history was performed using the Medical Questionnaire dated and signed September 26, 2014. In addition to the above, no additional complaints.

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PAST MEDICAL HISTORY: Hypertension.

SOCIAL HISTORY: He used to smoke one pack a day for 40 years, quit smoking 10 years ago. No alcohol.

FAMILY HISTORY: Father died at the age of 81 with myocardial infarction. Mother died at the age of 63, ALS.

ALLERGIES: None.

PRESENT MEDICATIONS: Medications were reviewed and can be found on the patient information sheet located in the chart.

PHYSICAL EXAMINATION: He is well developed and in no apparent distress.

Vitals: Blood pressure 120/84 with a heart rate of 78 and respiratory rate of 16. HEENT: Head is atrauinatic and normocephalic. Funduscopic examination not performed because of miosis. The rest of the ENT exam is normal.

Neck: Supple. No JVD and no carotid bruits. No lymphadenopathy.

Heart: Regular rhythm and rate. No murmur.

Lungs: Clear to auscultation and percussion.

Abdomen: Not examined.

Extremities: No clubbing, cyanosis or edema.

NEUROLOGICAL EXAMINATION: Orientation: He was found to be awake, alert, and oriented X3.

Recent and Remote Memory: Normal.

Attention Span and Concentration: Normal.

Cranial Nerve exam: There is conjugate gaze preference to the right side, but he can pass midline all the way to the opposite side. No nystagmus. Rest of cranial remarkable for left facial weakness, central type except visual field not tested.

Motor Exam: Motor strength in left upper and lower extremities is 0/5, right side 5/5.

Sensory Exam: Intact to all modalities.

Reflexes: Brisk on the right side 3/4, left 3+/4. Plantar response in the left side is extensor, right is flexor. Gait: He is in a wheelchair, unable to walk

Language: Intact.

Fund of Knowledge: Normal.

Speech: Normal.

Test of Coordination: Finger-to-nose and heel-to-shin normal.

IMPRESSION:

- 1. The patient suffered right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery. Initially symptoms possibly related to amaurosis fugax, but 40% of stenosis was not significant to justify endarterectomy in my opinion.
- 2. In my opinion second endarterectomy probably was not indicated particularly being done after almost eight hours after the new onset of symptoms.
- 3. Right M2 territory embolic, artery-to-artery infarction. Not so much change in comparison to previous MRI of the brain.
- 4. Lower back pain might be discogenic versus musculoskeletal in etiology.

PLAN:

- 1. Continue aspirin 325 mg a day for secondary stroke prophylaxis.
- 2. Obtain an MRI of the lumbosacral spine.

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3. I will ask Dr. Halloran, neuroradiologist to review CTA because of discropancy between my review and Dr. Cammoun review. Also we will ask him to review MRI done on September 3, 2014 and September 4, 2014. I encouraged the patient and his family to be very engaged in stroke rehabilitation.

4. Reevaluate the patient in one month or earlier as needed.

5. The patient will be notified as well as his family regarding MRI findings.

6. Spent one hour with the patient and his family as well as reviewing records

M.D., Ph.D. ekavac IB/ts/wkm

MH To: BEK	HLLEN MENURIAL HUSP	10/30 From: AMH Rauiol	w wor wa paizhion zona Page z of 3 .ogy Services
of the pe prohibite immediate Allen M MCGRE	rson to whom it is address d. If you have received th ly by telephone at 319-235 emorial Hospital W.WILLIAM M LOO, IA 50702	d, Any further disclos s copy in error, pleas	oure is strictly se nolify us ,
ADMITT ORDERI ATTEND CC: MEDICA	ING DR: BEKAVAC, IVO MD	DOB: FIN#:	DR. BEKAVAC,IVO MD TUS: Final D1/2014

REASON FOR EXAM: visual disturbance reading of outside films

CONSULTATION/REVIEW OF OUTSIDE FILMS:

I have been consulted to review a CT angiogram performed on William McGrew at ADI on August 18, 2014. The examination was reviewed on a 3-D physician workstation. Volume rendered and maximum intensity projection images were generated and reviewed

FINDINGS:

Aortic arch: Type II aortic arch. Minimal calcific atherosclerosis aortic arch. Minimal atherosclerosis in origin of the left common carolid artery without a hemodynamically significant narrowing. Origin of the right innominate and left subclavian arteries widely patent.

Right carotid: Small focus of calcific atherosclerosis at the origin of ICA producing a <u>32% diameter stenosis</u>. The post bulbar cervical ICA is widely patent.

The minimal right ICA diameter measures 3.2 cm. Post bulbar normal ICA diameter measures 4.7 cm

Left carotid: Neterogeneous atherosclerosis of the carotid bulb producing 22% maximal lumen diameter stenosis of the proximal ICA. The post bulbar cervical ICA is widely patent. Circumferential noncalcified moderate stenosis of origin of ECA.

The minimal loft ICA diameter measures 4.2 mm. Post bulbar normal ICA lumen dlameter measures 5.4 cm.

> PAGE 1 of 2 CONTINUE ON NEXT PAGE ALLEN MEMORIAL HOSPITAL

(Page 1 of 2. Continued on next page)

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ALLEN NEMORIAL HOSP

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MCGREW, WILLIAM M

Order No: 14ARA24244

Vertebrals: Short segmental heterogeneous atherosclerotic plaque producing near occlusive narrowing of the distal right vertebral urtery and focal noncalcific moderate stenosis of the distal left 'ertebral artery.

lso

igned by: John I Halloran MD on 10/9/2014 2:23 PM Report created with Powerscribe 360

ALLEN MEMORIAL HOSPITAL, WATERLOO IA. PAGE 2 of 2 MCGREW, WILLIAM M

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW,)	
,)	NO. LACV130355
Plaintiffs,)	
		PLAINTIFF WILLIAM MCGREW'S
VS.	/	SECOND SUPPLEMENTAL
		ANSWER TO INTERROGATORY
EROMOSELE OTOADESE, M.D.;)	NO. 16 PROPOUNDED BY
NORTHERN IOWA CARDIOVASCULAR)	DEFENDANT OTOADESE (Treating
AND THORACIC SURGERY CLINIC,)	Physicians)
P.C.; and DRISS CAMMOUN, M.D.,)	
)	
Defendants		

COMES NOW Plaintiff William McGrew and hereby submits his Supplemental

Answer to Interrogatory No. 9 propounded by Defendant Otoadese in the above case.

/s/ Martin A. Diaz Martin A. Diaz 000009676 ICIS AT0002000 1570 Shady Ct NW Swisher, IA 52338 319-339-4350 319-339-4426 fax marty@martindiazlawfirm.com Attorney for Plaintiffs

Copy: Counsel of Record on December 18, 2018

16. List the name, address, telephone number, and employer's name, address and telephone number of each person you expect to call as an expert witness (including, but not limited to, practitioners of the healing art) at trial, and with respect to each such individual, state:

- (a) The educational and occupational background of the expert;
- (b) All litigation in which each expert has been consulted or has given a deposition or has testified in trial, including the name and address of the court in which each case was pending, the names of the plaintiffs and defendants in each case, the name and address of the person engaging the services of such expert, the name of the person on whose behalf the expert testified, and whether such person was a plaintiff or defendant in the case;
- (c) The subject matter or area on which each expert will testify;
- (d) The substance of the facts and opinions, and a summary of the grounds for each opinion of each expert named by you in answer to this interrogatory;
- (e) Whether each identified expert has completed preparation for testifying and is ready to express final opinions in this case, or, if the answer is to the contrary, when each expert will have completed preparation and will be ready to express final opinions in this case; and

NOTE: Rule of Civil Procedure 1.508(1)(a) also <u>requires</u> that for an expert retained in anticipation of litigation or for trial the <u>expert shall SIGN the answer</u>. Please comply with this rule.

ANSWER:

Plaintiffs will disclose the names of any retained expert witnesses as part of their designation to the court consistent with the deadline established.

Otherwise, Plaintiff intends to call the following people who were not retained for purposes of this case:

1. One or more members of the staff at New Aldaya Lifescapes Nursing Home, 7511 University Avenue, Cedar Falls, Iowa 50613

2. Dr. John Musgrave, 212 West Dale Street, Waterloo, Iowa 50703

3. Dr. Richard Mauer, Mauer Eye Center, 2515 Cyclone Drive, Waterloo, Iowa 50701

4. Dr. Ivo Bekavac, 1735 W. Ridgeway Ave., Suite 112, Waterloo, Iowa 50701

6. Dr. John Halloran, P O Box 2758, Waterloo, Iowa 50704

7. To the extent needed, any other healthcare provider to discuss evaluation, care and treatment in the past and future for Bill McGrew.

The above individuals can testify to the evaluation, care and treatment of Bill McGrew and can testify to those facts known, mental impressions formed and opinions held as a result of their contact with him. This may include standard of care opinions (as to Dr. Bekavac and Dr. Halloran), causation opinions (Dr. Bekavac), permanency (Dr. Bekavac) and future care and treatment (Dr. Bekavac, New Aldaya, and Dr. Musgrave).

SUPPLEMENT TO INTERROGATORY 16 PURSUANT TO IRCP 1.500(2)(c)

Dr. John Musgrave, Dr. Matthew Smith, Dr. Richard Mauer, Dr. Ivo Bekavac, and Dr. John Halloran may testify pursuant to previously produced medical records and Plaintiff's Designation of Experts, filed February 6, 2018.

Dr. Bekavac will testify as to the standard of care, causation, and permanency. In his medical record dated September 26, 2014, Dr. Bekavac reviewed the CTA and determined a stenosis of the right ICA of approximately 40%. 40% stenosis is not sufficient to justify endarterectomy. The first and therefore the second endarterectomy were unnecessary and violated the standard of care. Dr. Bekavac is a Board Certified Neurologist, with Subspecialty Board Certification in Vascular Neurology and Neuroimaging (among others) who, as a treating physician, will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; the harm sustained by Bill McGrew; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse. He will also be asked to comment on the evaluation, care and treatment he has provided to Bill McGrew since he sustained the stroke on September 2-3, 2014.

Dr. Halloran, in his medical record dated October 9, 2014, reviewed the CTA and assessed a stenosis of 32%. Dr. Cammoun and Dr. Otoadese misread the CTA and

violated the applicable standard of care. Dr. Halloran is a Board-Certified Neuroradiologist who will be asked to comment on the evaluation of imaging studies on Bill McGrew that he reviewed at the request of Dr. Bekavac. He will also be asked to comment on the standard of care in the imaging evaluation of an individual like Bill McGrew, any breach of that standard of care, and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

Dr. Musgrave may be asked to testify about Bill McGrew's medical history before and after his stroke and his care and treatment of Bill McGrew.

Dr. Maurer may be asked to testify about his care and treatment of Bill McGrew.

Dr. Smith has provided handwritten responses to questions propounded by Kent Jayne and those responses are part of the report prepared by Mr. Jayne. In addition, Dr. Smith may be asked to testify to his care and treatment of Bill McGrew.

SECOND SUPPLEMENT TO INTERROGATORY 16 PURSUANT TO IRCP 1.500(2)(c)

In addition to the individuals noted in the "Supplement to Interrogatory 16 Pursuant to IRCP 1.500(2)(c)", Plaintiffs may call:

Allyson Landphair, ARNP, Northern Iowa Cardiovascular And Thoracic Surgery Clinic, P.C.;

Aubrey Donlea, PCT at Allen Memorial Hospital;

Rita Borrett, RN at Allen Memorial Hospital; and

Cydney Capps, PCT at Allen Memorial Hospital

to testify to their observations, assessment and care and treatment of Bill McGrew on September 3, 2014 and thereafter (in the case of Ms. Landphair) as outlined in the Allen Hospital medical records of Bill McGrew.

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW, Plaintiffs, vs.)) NO. LACV130355)) PLAINTIFFS' FIRST MOTION) IN LIMINE
EROMOSELE OTOADESE, M.D. and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C. Defendants)))))

COME NOW the Plaintiffs and move the Court in limine to prohibit Defendants, their counsel and any witnesses called to testify by the Defendants and their counsel, from offering any evidence or making any mention whatsoever of the following matters during any part of the trial of this cause, including but not limited to, voir dire examinations of the jury, opening statements, the presentation of evidence or closing arguments:

1. **Evidence or Claims that Plaintiffs were at fault**: Evidence regarding the fact that Plaintiffs were at fault or should have done something different to have prevented harm is inadmissible in this case and should be excluded as irrelevant and unfairly prejudicial. Iowa R. Evid. 5.412 and 5.403.

No claim of comparative fault has been made by Defendants.

2. Asking why or when Plaintiffs filed suit or their personal criticisms: Decisions regarding when and whom to sue and when and whom to dismiss are decisions made by counsel, with the consent of the clients. The Plaintiffs are not medical experts and have not been counseled by any experts. They are lay people and asking the Plaintiffs what criticisms they have or why they sued the defendants are improper opinion questions, as well as an invasion of the attorney-client privilege and relationship and invasion of the mental impressions of counsel. They are ultimately irrelevant as the only opinions that have probative value are those that come from experts. Plaintiffs rely upon Iowa Rule of Evidence 5.401 and 5.403 for the exclusion of this potential evidence, as well as the attorney-client privilege for the associated litigation and trial strategy.

3. Criminal Charges: Bill McGrew was convicted of OWI in 1992 and was charged with theft in the 1980s but the charges were dismissed. Any questions related to any criminal charge is irrelevant, potentially prejudicial and inadmissible as character evidence. Plaintiffs rely upon Iowa Rule of Evidence 5.401, 5.403 and 5.404 for the exclusion of this potential evidence.

4. Other litigation: Any questions related to other litigation, including a prior bankruptcy filing, is irrelevant, potentially prejudicial and inadmissible as

character evidence. Plaintiffs rely upon Iowa Rule of Evidence 5.401, 5.403 and 5.404 for the exclusion of this potential evidence.

5. Any other alleged cause of harm to Bill McGrew: Beyond the opinions already expressed in the defense experts' 1.508 disclosures or deposition testimony, Defendant has not provided notice about defense theories of an alternative cause of harm to Bill McGrew. Plaintiffs seek to avoid the prejudice that would result if Defendants' experts come up with a new theory on his condition. Iowa Rule of Civil Procedure 1.508(4) provides as follows:

1.508(4) Expert testimony at trial. The expert's direct testimony at trial may not be inconsistent with or go beyond the fair scope of the expert's disclosures, report, deposition testimony, or supplement thereto.

"The purpose of rule 1.508(4) 'is to avoid surprise to litigants and to allow the parties to formulate their positions on such evidence as is available." *West Realty, Inc. v. Fox*, 2009 Iowa App. LEXIS 593, 5-6 (Iowa Ct. App. June 17, 2009) (quoting *Millis v. Hute*, 587 N.W.2d 625, 628 (Iowa Ct. App. 1998)).

"An expert may not express a mere guess or conjecture, but he may testify to what might have been the cause of a certain result." *Millis v. Hute*, 587 N.W.2d 625, 628 (Iowa Ct. App. 1998). Here, any new theory regarding Bill's injuries would be mere guess or conjecture on the part of an expert or would have been made without providing adequate notice to Plaintiffs and should therefore be excluded. Without some type of expert link on cause of an injury for any new

theory, the probative value of any comment or evidence on such a theory would be substantially outweighed by the danger of unfair prejudice, confusion of the issues, and misleading the jury.

Thus, based on Iowa R. Civ. P. 1.508 and Iowa Rules of Evid. 5.401 and 5.403, any evidence suggesting a new theory on the cause of harm to Bill McGrew should be excluded from trial.

6. Limiting Defense Experts to the Fair Scope of Testimony Provided in Discovery: Additionally, as noted in ¶5, Plaintiffs request the Court enforce Rule 1.508(4) and limit defense experts to the "fair scope of the expert's disclosures, report, deposition testimony, or supplement thereto."

7. Bill McGrew's General Medical Records. Bill McGrew's records from the summer of 2014 through the present are probative evidence as these records relate to the incident that is the subject of this action.

However, the general health records of Mr. McGrew contain confidential medical information that is unrelated to the incident at issue. Unless Defendant can establish some reasonable relationship between the record and the issues involved, this Court should either require redaction of those records or exclude the records as irrelevant. Even if Defendants can suggest a potentially relevant use for the records, the records are still subject to Iowa Rule of Evidence 5.403, and without the assistance of an expert to put the document into context, there is a significant chance

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE	
MCGREW,	
) NO. LACV130355
Plaintiffs,	
) PLAINTIFFS' RESISTANCE
VS.) TO DEFENDANT
۷.3.) OTOADESE'S MOTION IN
	,
EROMOSELE OTOADESE, M.D.) LIMINE
and NORTHERN IOWA	
CARDIOVASCULAR AND	j l
THORACIC SURGERY CLINIC,	j l
P.C.,	
1.0.,)
Defendants	

COME NOW the Plaintiffs and in response to Defendant Otoadese's Motion in Limine states:

1. Informed Consent Theory: Plaintiffs have pled a cause of action for negligence to include a claim of informed consent. Defendants have been aware of this theory since the filing of the lawsuit. Dr. Otoadese was asked questions in his deposition regarding alternative treatment to surgery and the risks and benefits of the alternative treatment, including the option of proceeding without surgery. Dr. Otoadese has conceded that he did not discuss the option of medical therapy (medications) with Mr. McGrew and his daughter. In addition, Defendants were present when Dr. Adams (plaintiffs' retained expert) was asked questions at his deposition regarding the alternative treatment of medical therapy for ulcerative plaque, a condition that Dr. Otoadese concedes existed on August 18, 2014.

Rather than file a Motion for summary judgment on informed consent, defendants have chosen to file a motion in limine and place the court in the unenviable position of having to determine how the evidence will come in at trial without the benefit of all evidence on the issue. Defendants have chosen to selectively provide evidence regarding this issue, including choosing to ignore Dr. Otoadese's testimony on this issue.

Plaintiffs contend that a motion in limine is not the appropriate vehicle to deal with this issue. If the plaintiffs fail to prove this theory, then the court can grant a directed verdict. To prevent plaintiffs from even attempting to prove their claim, by limiting the evidence that they can offer, would constitute reversible error. Plaintiffs are entitled to the opportunity to present evidence on any theory or cause of action. It is unfair to require the plaintiffs to provide a preview of how they intend to prove this claim through the vehicle of a motion in limine. Plaintiffs have briefed the law on informed consent and the defendants have provided their viewpoint of the law in their motion in limine. Plaintiffs have provided the court with proposed jury instructions on the issue of informed consent. Plaintiffs refuse to provide defendants with an explanation of how they intend to handle the issue of informed consent in this case and the court should not reward the defendants for

failing to bring this issue to the court's attention via a Motion for Summary Judgment.

The primary purpose of a motion in limine is to avoid disclosing to the jury prejudicial matters which may compel declaring a mistrial. The trial judge is thereby alerted to an evidentiary problem which may develop in the trial. It should not, except upon a clear showing, be used to reject evidence.

State v. Johnson, 183 N.W.2d 194, 197 (Iowa 1971).

There is no proper basis for the defendant to ask this court to rule on the admissibility of evidence of a legitimate cause of action through a motion in limine.

2. Lost Chance Theory: In Wendland v. Sparks, 574 N.W.2d 327, 329

(Iowa 1998), the Iowa Supreme Court held that it is not necessary to plead loss of chance.¹

In his deposition, Dr. Adams testified that after Mr. McGrew was found to have signs and symptoms of a stroke on the morning of September 3, 2014 that there was still an opportunity to take him back to surgery to revascularize the artery, and in his opinion that such a timely effort would have resulted in avoiding the disabling condition that Mr. McGrew now lives with. The defendants disagree with that contention and claim that any such effort would not have changed the

¹ Defendants contend that *Wendland* nevertheless requires that the parties be alerted to the claim. This contention was rejected by the Court in *Mead v. Adrian*, 670 N.W.2d 174, 176-77 (Iowa 2003). The Court there cited to *Wendland* as support for the trial court permitting "amendments to conform to proof that added claims for....lost chance of survival".

outcome. Accordingly, the jury will have to determine if there was an opportunity that was lost because of inaction.

The jury's principal role will be to determine if the original carotid endarterectomy was necessary. The jury could conclude that surgery was necessary, but also conclude that there was a reasonable opportunity to repair the damage done by the original surgery and that Dr. Otoadese was negligent in not attempting to do so. The jury will then have to determine whether it would have made any difference and could come to the determination that there was a lost chance of a better outcome.

Defendants complaints are several. First, they claim that loss of chance was not pled. As noted above, this argument fails because loss of chance does not need to be pled and can in fact be permitted as late as during trial. Defendants further argue that they were unaware of this issue. However, they were clearly aware that Dr. Adams contended that the failure to return Mr. McGrew to surgery on the morning of September 3, 2014 was negligence and that such negligence was a cause of harm to Mr. McGrew. (See also Plaintiffs' Exh. 106). They also knew that their own experts would contend that it would not have made a difference. They knew that there was a dispute as to a chance of recovery from the stroke occasioned by the original surgery.

Second, they argue that Dr. Adams has testified to a traditional negligence claim and therefore loss of chance is not part of the case. This is also mistaken. In their trial brief, plaintiffs cite to *Mead v. Adrian* at 180, fn. 5, which holds, among other things, that "when the claim is submitted as an alternative to ordinary wrongful-death damages it is unrealistic to require a claimant who is arguing that it is more probable than not that death resulted from the defendant's negligence to also present evidence that the probability of survival was in fact some lesser percentage. The jury must determine the amount of proportionate reduction based on all of the evidence in the case."

Third, they appear to disagree with Plaintiffs' proposed jury instructions on how this theory is to be analyzed by the jury. However, that is not an appropriate issue on a motion in limine. That is a discussion to be held during the jury instruction conference. The issue before the court is whether the plaintiff should be permitted to go forward with a theory of recovery that has been recognized by the Iowa Supreme Court. Plaintiffs do not see how the defendant can ask this court to prohibit evidence about a subject that is an integral part of the factual record. If defendants are correct that it is a separate specification of negligence, and not a loss of chance claim, then the evidence still comes in for purposes of assessing that claim. **3. Treating Healthcare Providers:** Defendants' Motion in Limine to limit the expert testimony of Drs. Bekavac and Halloran is based on the mistaken belief that plaintiffs have failed to produce an expert report as required by Iowa Rule of Civil Procedure 1.500(2)(b). The argument then follows that, because an expert report has not been produced, Plaintiffs are not permitted to offer testimony from these physicians as to the standard of care and the breach of the standard of care.

As will be discussed below, Plaintiffs complied with the court's discovery plan and the more applicable rule, Iowa Rule of Civil Procedure 1.500(2)(c). Accordingly, Defendants' motion in limine must be denied.

a. Plaintiffs Have Properly Designated Their Expert Witnesses and Disclosed Their Proposed Testimony

The applicable discovery plan required that plaintiffs designate their expert witnesses by February 7, 2018. Plaintiffs complied with that requirement.

 $(Plaintiffs' Exh. 103)^2$

The discovery plan then stated that "any disclosures required by Iowa Rule of Civil Procedure 1.500(2)(b) will be provided" by March 7, 2018. That rule states in relevant part as follows:

Unless otherwise stipulated or ordered by the court, this disclosure must be accompanied by a written report—prepared and signed by the witness—*if* the witness is one retained or specially employed to provide expert testimony in the case or one whose duties as the party's employee regularly involve giving expert testimony.

² All exhibits cited to will be found at the end of this document.

(Emphasis added)

This rule only applies to retained experts. Drs. Bekavac and Halloran, the focus of Defendants' motion, are treating physicians, and were not retained or specially employed to provide expert testimony in this case. Therefore, the discovery plan's requirement that an expert report be provided does not apply to them. The discovery plan is silent as to those individuals that are not retained or specially employed. Those individuals are governed by Iowa Rule of Civil Procedure 1.500(2)(c), which provides as follows:

Witnesses who do not provide a written report. Unless otherwise stipulated or ordered by the court, if the witness is not required to provide a written report, this disclosure must state:

(1) The subject matter on which the witness is expected to present evidence under Iowa Rules of Evidence 5.702, 5.703, or 5.705.

(2) A summary of the facts and opinions to which the witness is expected to testify.

(Emphasis added). The rule is plain and simple. There is no requirement that a report be provided for Drs. Bekavac and Halloran. However, plaintiffs must provide a summary of the facts and opinions to which the witness is expected to testify. Plaintiffs complied with that requirement on March 7, 2018 when it produced a supplemental answer to interrogatory for treating physicians. (Plaintiffs' Exh. 105). The initial answer to interrogatory, which is found in Exhibit

102 identified several treating physicians including Drs. Bekavac and Halloran and provided the following statement:

The above individuals can testify to the evaluation, care and treatment of Bill McGrew and can testify to those facts known, mental impressions formed and opinions held as a result of their contact with him. This may include standard of care opinions (as to Dr. Bekavac and Dr. Halloran), causation opinions (Dr. Bekavac), permanency (Dr. Bekavac) and future care and treatment (Dr. Bekavac, New Aldaya, and Dr. Musgrave).

The supplemental answer to interrogatory went into greater detail regarding both Drs. Bekavac and Halloran. (Plaintiffs' Exh. 105). This included disclosure that these individuals would testify to the standard of care and the breach of the standard of care.

In addition, plaintiffs had already produced as part of the initial disclosures all medical records including the records of Drs. Bekavac and Halloran. The medical records produced include Exhibits 11, 12 and 13, which detail the key opinions held by both treating doctors, namely that the CT angiogram read by Dr. Otoadese does not demonstrate right carotid artery stenosis of 70%. Rather, Dr. Halloran contends that the correct reading of that CT angiogram is 32% and Dr. Bekavac contends that the correct reading of that CT angiogram is no more than 40%. Dr. Bekavac also opined that because the CT angiogram was misread there was no justification for the surgery that was performed on Mr. McGrew. Accordingly, Plaintiffs complied fully with the disclosure requirement of IRCP 1.500(2)(c).³

Defendants' contention that Plaintiffs were obligated to provide an expert report pursuant to the retained expert disclosure rule is simply mistaken. These doctors were treating physicians. As such, Plaintiffs had no obligation to obtain a written report from each. In fact, that's contrary to the entire framework of the disclosure requirements. The intent and purpose of the rules is to recognize that, when it comes to treating physicians, Plaintiffs have little to no control over those individuals. That is totally different than the scenario in which Plaintiffs go out and hire or retain an expert for the purpose of testifying at trial. In that scenario, Plaintiffs can obtain a report prepared by the retained expert. Treating physicians are not required to prepare special reports because they've not been retained for that purpose. Rather, treating physicians can rely upon any progress notes or medical records that they have generated themselves in the care and treatment of the plaintiff and can rely on the mental impressions they developed during the treatment process and any opinions formed from the facts obtained and impressions made.

³ Defendants contend that these medical records are hearsay and may not be admitted. Plaintiffs disagree, but regardless, these records identify the facts and opinions that these doctors developed at the time they saw Mr. McGrew or his imaging studies.

The Iowa rules recognize that treating physicians can develop mental impressions and opinions arising out of the care and treatment that they provide. That is certainly what happened here regarding Drs. Bekavac and Halloran. They are not required to provide expert reports. Plaintiffs have otherwise complied with the Iowa rules.

b. Defendants were given the opportunity to depose Drs. Bekavac and Halloran and waived that right

Over a 5-month period, Defendants were given the opportunity to depose these treating physicians. After demanding their depositions, the defendants did an about face and withdrew their requests. Defendants waived their right to depose these treating physicians.

Iowa Rule of Civil Procedure1.508(1)(a) allows a party to "depose any person who has been identified as an expert whose opinions may be presented at trial." This rule is not limited to retained experts but, if experts are retained, then their depositions can only take place after they have produced written reports. In the case of Drs. Bekavac and Halloran, since they were not retained, their depositions could be taken at any time.

In their Motion to Strike Experts, plaintiffs provide an extensive history that shows that Plaintiffs made these two treating physicians available for a deposition. In the case of Dr. Halloran, all efforts to depose him went through his own lawyer. As for Dr. Bekavac, Plaintiffs provided a direct phone number where they could

contact Dr. Bekavac to schedule his deposition. After many months of efforts to obtain deposition dates from counsel for the defendants, the parties agreed on 2 days in January 2019 for the depositions of these two treating physician experts. Yet, shortly after those dates were agreed to, the defendants canceled the depositions and waive their right to take those depositions. (Plaintiffs' Exh. 202).

c. An IRCP 1.500(2)(c) disclosure is the equivalent of an IRCP 1.500(2)(b) report, especially when supported by medical records produced by the treating physician

In this case, Plaintiffs provided two forms of expert disclosure regarding the proposed testimony of these treating physicians. First, they provided the medical records generated by these physicians. These are business records that are made as part of medical diagnosis or treatment and are therefore admissible. They detail the thought process of both physicians and provide an outline of those facts, mental impressions and opinions formulated at the time they provided care and treatment. Second, Plaintiffs provided the expert disclosures required pursuant to IRCP 1.500(2)(c).

Defendants' complaint is that they have not been provided with an "expert report" under IRCP 1.500(2)(b). But what they fail to acknowledge is that they have been provided with the equivalent if not more than an expert report. The medical records alone provide a clear statement of what Dr. Bekavac was thinking, the concerns he had raised with the family, and his belief that he needed to confirm

that information by having Dr. Halloran review the CT angiogram. That's significant information to put in a medical report. It is a rare event when a physician criticizes another physician in the medical chart. It is not uncommon for one physician to raise concerns with patients about the care provided by another physician, but it is exceedingly uncommon for those thoughts and opinions to find their way into the patient's chart. The purpose of an expert report as requested by these defendants is to alert them to the potential line of testimony of the expert witness. The medical records prepared by Drs. Bekavac and Halloran tell a very direct story. Defendants' contention that they need a separate expert report is meritless.

In addition, these defendants also received supplemental answers from the plaintiffs stating that they intended to utilize the testimony of these treating physicians as part of the proof of negligence in this case and outlined that evidence. Defendants recognized the potential testimony because they sought to take the depositions of these individuals.

When the Supreme Court authorized the change to the rules regarding expert disclosures, it sought to create equivalencies in different experts.⁴ It recognized

⁴ The changes were generally outlined in an August 28, 2014 order issued by the Supreme Court. The overall changes to the discovery process came in response to the Iowa Civil Justice Task force report issued in 2012. A review of the Task Force report reflects that the task force could not come to an agreement regarding changes to the expert disclosure requirement. It appears that the Supreme Court created this system on its own without a specific recommendation from the task force. The changes went into effect in 2015.

that in some cases there will be expert witnesses that are not retained or specially employed for purposes of litigation. In creating the two separate subparagraphs of the rule, the court struck this equivalency by demanding different methods for disclosure. If you retain an expert, you can control that expert and therefore you should be expected to produce an expert report prepared by that expert. On the other hand, if your case happens to have a witness that has special training and skill, you should be able to utilize that individual without demanding that he produce a written report that is the equivalent of what that expert may already have said in other writings. In other words, why should we expect a treating physician to prepare or sign off on an affidavit or report when that physician has already created the equivalent of such a report in the course of their care and treatment of the patient? But the court was also sensitive to the fact that the opposing party would need to know that the witness would be used as part of the case. Therefore, the court created a separate but equal mechanism to an expert report from a nonretained expert that balanced these concerns.

Defendants' argument seeks to undermine the balance created by IRCP 1.500(2). In short, they are demanding an expert report from a treating physician. This argument cannot be allowed to succeed because it then would require a party interested in using a non-retained expert to get an expert report to satisfy the opposing party. Defendants also contend that *Hansen v. Central Iowa Hospital Corp.*, 686 N.W.2d 476 (Iowa 2004) is still good law. It's not entirely clear that it is, but to the extent that it is, the key practice pointer is that if you intend to use treating physicians to discuss matters beyond their role as treaters then you should make disclosure. The disclosure rules in existence at the time that *Hansen* was decided are different than the current rules. So long as one complies with the disclosure rules in effect at the time of the case, the requirements of *Hansen* are met. Plaintiffs clearly met the disclosure requirements and the defendants have not been prejudiced in any way. They have known about these individuals since the filing of this lawsuit and have chosen not to depose them.

4. Irrelevant and Prejudicial Subjects: Defendants have raised eight separate issues described under the general heading of "irrelevant and prejudicial subjects." Plaintiffs will respond to each by indicating the letter applicable to the request:

a. **Criticism of physicians by other physicians:** It is a fact in this case that Dr. Bekavac disagrees with the interpretation of the CT angiogram of August 18, 2014 and is critical of the decision to perform surgery on Mr. McGrew. It is also a fact that Dr. Halloran disagrees with the interpretation of the CT angiogram of August 18, 2014. Such criticisms are usually reserved, if at all, for the peer review

process. That didn't happen here. Plaintiffs should be permitted to establish these facts and should not be limited in the words they use to describe these facts.

b-c. **Dr. Otoadese's qualifications:** Dr. Otoadese has testified that in 2008-2009 he "voluntarily" surrendered his hospital privileges to perform heart surgery, which at the time constituted 50-60% of his overall time performing surgeries. Dr. Otoadese then filed suit against Allen Memorial Hospital relating to these surrendered privileges and reached a confidential settlement unknown to these Plaintiffs. (*See Otoadese v. Allen Memorial Hospital*, Black Hawk County, LACV114625). But, notwithstanding that settlement, Dr. Otoadese has not performed "open heart" surgeries since 2009. He has admitted that at the time he was performing "open heart" surgeries, they constituted 50-60% of his surgery time and approximately 30% of his overall surgeries.

In 2012, Dr. Otoadese was "kicked out" (terminated)⁵ from Cedar Valley Medical Specialists and on January 1, 2013 he opened Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. In the summer of 2014, Dr. Otoadese's surgeries were limited to vascular and nonvascular thoracic areas of the

⁵ These are Dr. Otoadese's words. He explains in his deposition that he was terminated because CVMS was not able to get insurance to cover his practice. Plaintiffs do not know if that is an accurate reflection of why, but they do not intend to offer that evidence unless the defendant wishes to.

body and he was still not performing open-heart procedures---consistent with the fact that he no longer had privileges to perform open heart surgeries.

One of Dr. Otoadese's experts is Dr. James Levett, a cardio thoracic surgeon from Cedar Rapids. Dr. Levett was retained as an expert witness by Allen Hospital in the lawsuit filed by Dr. Otoadese. Dr. Levett was hired to testify to the appropriateness of the decision to withhold surgical privileges from Dr. Otoadese to perform open-heart procedures.

The above facts are undisputed.

It is also undisputed that on August 18, 2014, Mr. McGrew went to see Dr.

Otoadese who recommended surgery and did not discuss with Mr. McGrew

alternative treatment for his condition that did not require surgery.

A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue.

Iowa Rule of Evidence 5.702

Iowa law existing at the time this case was filed, Iowa Code §147.139,

provided as follows:

If the standard of care given by a physician....is at issue, the court shall only allow a person to qualify as an expert witness and to testify on the issue of the appropriate standard of care if the person's medical...qualifications relate directly to the medical problem or problems at issue and the type of treatment administered in the case.

Dr. Otoadese will testify in his own defense. Dr. Otoadese is an expert witness and he will testify to the fact that he did not violate the standard of care. In order to assess Dr. Otoadese's credibility as an expert, the court must provide the plaintiff the opportunity to question Dr. Otoadese's qualifications including any limitations on his hospital privileges, and the successes and failures that he has had as a physician and surgeon. This includes any motivation that he may have had to perform surgery on Mr. McGrew. The evidence will include the fact that his surgical practice had taken a substantial downturn in 2009 when he was not allowed to perform open-heart procedures. The evidence will also include the fact that his surgical practice was significantly affected by his termination ("kicked out", as he termed it) from Cedar Valley Medical Specialists. In order to properly assess Dr. Otoadese's skill as a physician and his motive for recommending surgery, the jury needs to be given all relevant information. Failure to provide the jury with that information would mislead the jury.

If Dr. Otoadese were called as a retained expert, plaintiffs would be permitted to inquire about the hospital privileges maintained by him and whether he had ever been terminated from a clinical group. That information would be relevant to assess his qualifications to render standard of care opinions.

In addition to the undisputed facts regarding his hospital privileges at Allen Memorial Hospital, and his termination from Cedar Valley Medical Specialists,

there is the additional evidence that one of Dr. Otoadese's expert witnesses has

previously testified as an expert witness against Dr. Otoadese in the case involving

his privileges to perform open-heart procedures at Allen Memorial Hospital.

This inquiry into the qualifications of any expert, including a defendant who

was an expert, has been recognized by the Iowa Supreme Court:

We are committed to a liberal rule on admissibility of expert testimony, *Wick v. Henderson*, 485 N.W.2d 645, 648 (Iowa 1992), and the admission of such testimony rests within the sound discretion of the district court. *Tappe v. Iowa Methodist Medical Ctr.*, 477 N.W.2d 396, 402 (Iowa 1991). Iowa Rule of Evidence 702 has "codified Iowa's existing liberal rule on the admission of opinion testimony." *Hutchison v. American Family Mut. Ins. Co.*, 514 N.W.2d 882, 885 (Iowa 1994). The United States Supreme Court reaffirmed this approach in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 125 L. Ed. 2d 469, 113 S. Ct. 2786, 2799, 125 L. Ed. 2d 469, 485 (1993). Rule 702 provides:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.

Further, in its comments to rule 702, the advisory committee stated:

If [pursuant to Iowa Rule of Evidence 104(a)] *the Court is satisfied that the threshold requirements have been met, the witness should be allowed to testify.* **All further inquiry regarding the extent of his** [or her] qualifications go to the weight that the fact finder can give such testimony under Rule 104(e).

Carolan v. Hill, 553 N.W.2d 882, 888 (Iowa 1996) (Italics in original; bold added)

In Hutchison v. American Family Mut. Ins. Co., 514 N.W.2d 882 (Iowa

1994), the plaintiff objected to testimony from defendant's retained expert because

he was not board certified in neuropsychology and because he was a psychologist

and not a medical doctor testifying about medical causation. In rejecting this

objection, the court took pains to point out that the ultimate assessment of

qualifications was left to the trial process including cross-examination and jury

assessment of the witness. The court stated:

Dr. Moore has board certification as a clinical psychologist, holds a Ph.D. in clinical psychology, and has substantial experience in neuropsychology. Although Dr. Moore lacked board certification in neuropsychology, we believe this fact went to the weight of his testimony, not its admissibility.

Although few of these restrictions on experts strike us as fundamentally unsound, we refuse to impose barriers to expert testimony other than the basic requirements of Iowa rule of evidence 702 and those described by the Supreme Court in *Daubert*. The criteria for qualifications under rule 702-knowledge, skill, experience, training, or education--are too broad to allow distinctions based on whether or not a proposed expert belongs to a particular profession or has a particular degree.

We understand the concern that expert testimony regarding the causes of personal injury can fall "wholly in the realm of conjecture, speculation, and surmise." Nevertheless, we agree with the *Daubert* Court that the trial court in its discretion and the jury in its deliberation provide the most effective determination of the admissibility and weight of expert psychological testimony.

Similarly, we believe with the aid of vigorous cross examination, the jury is fully capable of detecting the most plausible explanation of events.

Moreover, plaintiffs had ample opportunity to discredit Dr. Moore. Plaintiffs' counsel subjected Dr. Moore to *thorough cross examination regarding his qualifications* and the basis of his testimony, *placing special emphasis on his lack of medical qualifications*. ...

Id. at 886-889 (Italics added)

Finally, in *Andersen v. Khanna*, 913 N.W.2d 526 (Iowa 2018), the Court held that the personal characteristics of a physician may establish a duty of disclosure as part of obtaining informed consent for treatment. In discussing the duty to disclose surgical experience, the Court noted the following:

Indeed, at trial several experts testified regarding the number of Bentall procedures they had performed and their training to perform the procedure in order to establish their competency to testify as expert witnesses. *It stands to reason that if such information is relevant to establishing a witness's expertise, such information could be material to a reasonable patient's decision to or not to undergo a particular treatment.*

Id. at 540 (emphasis added).

The Court cited with approval a Louisiana Court of Appeals decision that "held the physician had a duty to disclose his chronic alcohol abuse." *Andersen* at 542 (citing to *Hidding v. Williams*, 578 So. 2d 1192, 1196 (La. Ct. App. 1991)). The Court makes clear that the qualifications of a physician may be relevant to consent, and in the process highlights that a physician's history is important in assessing their credibility.

Defendants contend that permitting evidence of the qualifications of the defendant physician would be more prejudicial than probative. However, it would be more prejudicial not to tell the jury about the qualifications and working history of this physician. Under what circumstances is the qualifications of an expert physician not probative? Under what circumstances is the working history of an expert physician not probative? They clearly are. If prejudice exists, it does so

because defendant's qualifications create such prejudice. It is not prejudice created by the plaintiffs. If any such prejudice exists, it cannot outweigh the probative value of a jury understanding a physician's qualifications.

d. Leased Space for Ultrasounds: The fact that Dr. Otoadese has access to an ultrasound facility is relevant since one of the options he had was to perform an ultrasound on Mr. McGrew's carotid arteries before recommending surgery. The location of that facility is at ADI, where Dr. Cammoun is employed. The fact that Dr. Otoadese leases space from ADI and Dr. Cammoun, and that Dr. Otoadese routinely refers patients to Dr. Cammoun are also relevant to understanding the relationship between these two individuals and why Mr. McGrew ends up there. There is nothing prejudicial about this information.

e. Financial Motives behind medical care: Defendants cite to a series of facts that are undisputed. It's not clear what the complaint is. If the defendants' contention is that plaintiffs should not be permitted to comment on the evidence that is admissible then they are mistaken. Again, not permitting reasonable argument from admissible evidence can be more prejudicial than to permit such argument. Apparently, defendants prefer that the jury be kept in the dark about how Dr. Otoadese practices medicine.

f. **Medical Chart**: Plaintiffs don't plan to make this argument but, if the door is opened, they reserve the right to argue this.

g. Relationships between Dr. Otoadese and Drs. Bekavac and Halloran: The evidence will be that there is no ill will between all physicians involved. This is relevant because a jury may conclude without such information that there is ill will between these individuals and that is what led Drs. Bekavac and Halloran to criticize the CT angiogram interpretation and the surgery. Therefore, this is probative evidence and there is no prejudice to its admissibility.

h. **Board Certification**: Please refer to the discussion on qualifications in subparagraph b-c. If Dr. Otoadese were first in his class in medical school, the Defendants would be parading that before the jury; but if he struggled to be board certified, the defense would want that excluded.

5. Other patients, claims or adverse outcomes of Dr. Otoadese:

Plaintiffs do not intend to discuss specific patients claims or adverse outcomes. However, during his deposition Dr. Otoadese was interested in talking about other patients (not by name). If he persists, then plaintiffs do intend to discuss with him prior lawsuits or adverse outcomes. Defendants do not get to talk about his practice as if it were pristine and without problems.

6. Peer Review: Plaintiffs do not intend to offer any such evidence during their case in chief. However, if Dr. Levett one of defendants' retained experts testifies, plaintiffs intend to ask him about his involvement in the lawsuit filed by Dr. Otoadese against Allen Hospital. Dr. Levett was retained by Allen Hospital to

testify to the decision by the hospital to deny certain surgical privileges to Dr. Otoadese.

7. Out of Court Statements of Health Care Providers: Plaintiffs believe that any out-of-court statements should be handled on a case-by-case basis. This is because some statements made by health care providers to the plaintiffs would not be hearsay because they would either be subject to an exception or because they would not be offered for the truth of the matter asserted but rather offered for other purposes such as state of mind and decision-making.

8. Future Medical Expenses: Iowa Code §147.136 does not allow an award of medical expenses that have been paid for or will be paid for by insurance or a governmental program, with some exceptions. However, that statute does not prohibit evidence of future expenses. It just does not permit recovery if those expenses will be paid for by insurance or a governmental program. The difficulty is that for some expenses there may not be any coverage, or any coverage may be uncertain. Plaintiffs intend to offer the testimony of Kent Jayne about the cost of future life care and Mr. Jayne can testify as to whether those expenses are expected to be covered by insurance or a governmental program. Plaintiffs' principal future life care claim will be related to bringing Mr. McGrew home and providing him with in-home care. This type of care is usually not covered by insurance or governmental program. Plaintiffs anticipate that they will make this distinction

known to the jury during Mr. Jaynes testimony. Plaintiffs contend that it would be error for the court to preclude such evidence. The better approach is to deal with it in the jury instruction process.

9. Liability Insurance Coverage: No objection.

10. Punitive Damages: No objection.

11. Financial Disparity: No objection.

12. Settlement: With the understanding that Dr. Cammoun is a released

party under Chapter 668, Plaintiffs do not object to the balance of the request.

Respectfully submitted,

MARTIN DIAZ LAW FIRM

<u>/s/ Martin A. Diaz</u> MARTIN A. DIAZ 000009676 ICIS AT0002000 1570 Shady Ct. NW Swisher, IA 52338 319-339-4350 telephone 319-339-4426 facsimile Attorney for Plaintiffs

MARK L. CHIPOKAS PC

By: <u>/s/ Mark L. Chipokas</u> Mark L. Chipokas, AT0001418 866 First Avenue NE P.O. Box 1261 Cedar Rapids, Iowa 52406-1261 (319) 366-7888 (888) 466-1350 Fax E-mail: <u>mark@mlchipokaspc.com</u>

copy: Per EDMS

E-FILED 2019 FEB 14 10:10 AM BLACKHAWK - CLERK OF DISTRICT COURT



September 26, 2014

RE: William McGrew DOB:

Ivo Bekavac, MD, PhD

1753 W. Ridgeway Avenue

Dept. of Neurology

Waterloo, IA 50701

FAX 319.833.5955

319.833.5954

Suite 112

Mr. William McGrew comes in self-referral as well as his family for second opinion about stroke.

HISTORY OF PRESENT ILLNESS: According to the patient and his family on August 5, 2014 he had episode of visual problem, describes everything was greying on his eye lasting between one to two minutes. No associated weakness involving any part of his body. He was otherwise healthy except hypertension. He went to see Dr. Mauer, who send him to see Dr. Otoadese and CTA was done of the extracranial circulation on August 18, 2014. It was read by Dr. Cammoun, who felt there was right ICA stenosis around 65%. I did review personally and showed to the patient and his daughter and son and my opinion stenosis of right ICA is Subsequently Dr. Otoadese performed right carotid artery approximately 40%. endarterectomy on September 2, 2014. Prior to the surgery patient was asymptomatic. He was not taking aspirin when this event occurred and was just started a week or so before the surgery. Extensive records reviewed around 60 pages. After surgery he was doing great and then very next morning around 7:10 it was noticed by nurse as well as his daughter the patient was confused and had left facial droop. Dr. Almullahassani, a neurologist was called who ordered CTA which apparently showed right ICA occlusion. CTA was done at 11:05 and symptoms started around 7:10 a.m. MRI of the brain showed acute right M2 territory ischemic infarct and some changes involving basal ganglia involving territory of the lenticulostriate arteries. Dr. Almullahassani requested second endarterectomy and clot removal. Apparently Dr. Otoadese was not willing to do so, but then Dr. Almullahassani according to the patient's daughter asked for opinion by Dr. Karimi, a vascular surgeon at Covenant Medical Center was about to transfer the patient, then finally Dr. Otoadese came back and performed right endarterectomy between 3:00 to 3:30 p.m. After the surgery the patient had complete weakness on the left side. Prior to that family is not sure whether he had any weakness involving his left hand at all. Also became confused and eyes were looking to the right side. He has been essentially the same since the second surgery. Repeat MRI done following day did reveal very similar area of infarction according to my review essentially unchanged from previous one done day before. The patient has been on aspirin for stroke prophylaxis 325 mg a day. Since the surgery he has been also complaining of lower back pain on the left side without shooting distally. No imaging of the lumbosacral spine. He has been doing stroke rehabilitation. The patient wants to know exactly the reasoning behind surgery whether first surgery and second surgery was indicated.

REVIEW OF SYMPTOMS: Complete review of (14) systems and complete past medical and social history was performed using the Medical Questionnaire dated and signed September 26, 2014. In addition to the above, no additional complaints.

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William Mcgrew September 26, 2014 Page 2

PAST MEDICAL HISTORY: Hypertension.

SOCIAL HISTORY: He used to smoke one pack a day for 40 years, quit smoking 10 years ago. No alcohol.

FAMILY HISTORY: Father died at the age of 81 with myocardial infarction. Mother died at the age of 63, ALS.

ALLERGIES: None.

PRESENT MEDICATIONS: Medications were reviewed and can be found on the patient information sheet located in the chart.

PHYSICAL EXAMINATION: He is well developed and in no apparent distress.

Vitals: Blood pressure 120/84 with a heart rate of 78 and respiratory rate of 16.

HEENT: Head is atraumatic and normocephalic. Funduscopic examination not performed because of miosis. The rest of the ENT exam is normal.

Neck: Supple. No JVD and no carotid bruits. No lymphadenopathy.

Heart: Regular rhythm and rate. No murmur.

Lungs: Clear to auscultation and percussion.

Abdomen: Not examined.

Extremities: No clubbing, cyanosis or edema.

NEUROLOGICAL EXAMINATION:

Orientation: He was found to be awake, alert, and oriented X3.

Recent and Remote Memory: Normal.

Attention Span and Concentration: Normal.

Cranial Nerve exam: There is conjugate gaze preference to the right side, but he can pass midline all the way to the opposite side. No nystagmus. Rest of cranial remarkable for left facial weakness, central type except visual field not tested.

Motor Exam: Motor strength in left upper and lower extremities is 0/5, right side 5/5.

Sensory Exam: Intact to all modalities.

Reflexes: Brisk on the right side 3/4, left 3+/4. Plantar response in the left side is extensor, right is flexor. **Gait:** He is in a wheelchair, unable to walk

Language: Intact.

Fund of Knowledge: Normal.

Speech: Normal.

Test of Coordination: Finger-to-nose and heel-to-shin normal.

IMPRESSION:

- 1. The patient suffered right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery. Initially symptoms possibly related to amaurosis fugax, but 40% of stenosis was not significant to justify endarterectomy in my opinion.
- 2. In my opinion second endarterectomy probably was not indicated particularly being done after almost eight hours after the new onset of symptoms.
- 3. Right M2 territory embolic, artery-to-artery infarction. Not so much change in comparison to previous MRI of the brain.
- 4. Lower back pain might be discogenic versus musculoskeletal in etiology.

PLAN:

- 1. Continue aspirin 325 mg a day for secondary stroke prophylaxis.
- 2. Obtain an MRI of the lumbosacral spine.

William Mcgrew September 26, 2014 Page 3

- 3. I will ask Dr. Halloran, neuroradiologist to review CTA because of discrepancy between my review and Dr. Cammoun review. Also we will ask him to review MRI done on September 3, 2014 and September 4, 2014. I encouraged the patient and his family to be very engaged in stroke rehabilitation.
- 4. Reevaluate the patient in one month or earlier as needed.
- 5. The patient will be notified as well as his family regarding MRI findings.
- 6. Spent one hour with the patient and his family as well as reviewing records

Sekavac, M.D., Ph.D. IB/ts/wkm

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IVO BEKAVAC, M.D., Ph.D.

ADDRESS:

Department of Neurology Cedar Valley Medical Specialists 1753 W. Ridgeway Avenue, Suite 112 Waterloo, IA 50701 E-mail: NEUROMARINA@AOL.COM

EDUCATION:

Medical school:University of Zagreb, Croatia
M.D., September 1989Ph.D.:University of Zagreb/Hahnemann University,
Zagreb/Philadelphia
Ph.D. in Neuroscience, April 1995

CLINICAL EXPERIENCE:

Internship - Clinical Hospital Split, Croatia, 1989-90 Internship - Cleveland Clinic, Cleveland, USA, 1994-95 Neurology residency program - Cleveland Clinic, USA, 1995-98 Staff Neurologist – Waterloo, USA, 1998- present

SPECIFIC TRAINING:

EEG/EP/Epilepsy -Cleveland Clinic, Cleveland, USA, 1996-98(6 months) **Minifellowship in Epilepsy** - Bowman Gray School of Medicine, 1997 **EMG course** -Cleveland Clinic, Cleveland, USA, 1997-98 (6 months) **Neurovascular ultrasound (carotid and TCD)**-Cleveland Clinic (1 month) **Neurovascular ultrasound course** - Bowman Gray School of Medicine, 1998

BOARD CERTIFICATION:

American Board of Psychiatry and Neurology - 2000 American Board of Electrodiagnostic Medicine - 2001 American Society of Neuroimaging – 2002 (MRI/CT & Neurosonology) Subspecialty Board in Vascular Neurology, ABPN – 2006 Neuroimaging Subspecialty Board, UCNS – 2013

RESEARCH EXPERIENCE:

Student - research program in clinical cardiology, Department of Cardiology, Clinical Hospital Split, Croatia, 1986-89

Post Doctoral Fellow - Department of Anesthesia Research, McGill University, Montreal, Canada, 1990-91:

-study of activated ion channels using patch clamp technique (neuroscience-electrophysiology) -study of speed of action of various muscle relaxants using iontophoresis

Research Associate, Department of Physiology, Hahnemann University, Philadelphia, USA, 1991-1994:

-effect of cocaine on the somatosensory signal processing using single unit extracellular recording (in vivo)

Resident-cerebrovascular clinical research, Cleveland Clinic, 1995-98

TEACHING EXPERIENCE:

Teaching Assistant-Department of Physiology, McGill University, 1990-91 ACLS Course Instructor -First Croatian World Congress, Croatia, 1996 Assistant professor of neurology- Medical School Split Adjunct associate professor of neurosurgery-University of Iowa Hospitals/Clinics

PROFESSIONAL MEMBERSHIP:

American Academy of Neurology, since 1997

LICENSURE:

- 1. Iowa, since 1998
- 2. **Ohio**, since 1995
- 3. Utah, since 1995

LIST OF PUBLICATIONS:

Papers:

1. Miric D, Rumboldt Z, Tonkic A, **Bekavac I.** (1989). Out-of-hospital sudden death rate: some peculiarities in circadian rhythm. **Medicina** 25:69-71.

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- Rumboldt Z, Miric D, Bekavac I. (1988). The rhythm of dying due to heart stroke during the day. The Second Croatian Symposium on Cardiovascular Disease. 54:61-64.
- 3. Law Min JC, **Bekavac I**, Glavinovic MI, Donati F, Bevan DR. (1992). Iontophoretic study of speed of action of various muscle relaxants. **Anesthesiology** 77:351-356.
- 4. Bekavac I, Waterhouse BD. (1995). Systemically administered cocaine selectively enhances long-latency responses of primary sensory cortical neurons to peripheral stimuli. J. Pharmacol. Exptl. Therapeut. 272:333-342.
- 5. Waterhouse BD, Gould EM, **Bekavac**, I. (1996). Monoaminergic substrates underlying cocaine-induced enhancement of somatosensory evoked discharges in rat barrel field cortical neurons. J. Pharmacol. Exptl. Therapeut. 279:582-592.
- Bekavac I, Hanna JP, Wallace RC, Powers J, Ratliff NB, Furlan AJ, (1997). Intraarterial thrombolysis of myxomatous proximal middle cerebral artery occlusion. Neurology 49:618-620.
- 7. Bekavac I, Hanna JP, Sila CA, Furlan AJ. (1999). Warfarin and low-dose aspirin for stroke prevention in patients with severe intracranial stenosis. Journal of Stroke and Cerebrovasc. Diseases 8:33-37.
- 8. Bekavac I, Halloran JI. (2003). Meningocele induced positional syncope and retinal hemorrhage. AJNR 24:838-839.
- 9. Halloran JI, **Bekavac I.** (2004). Unsuccessful tissue plasminogen activator treatment of acute stroke caused by a calcific embolus. **J.** Neuroimaging 14:385-387.
- 10. **Bekavac I,** Halloran JI, Frazier S, Sprung J, Bourke DL. (2006). Chiropractic manipulation induced dissection and subsequent aneurysm formation of the internal carotid artery, or if it ain't broke, don't fix it. **J. Explore** 2:150-151.
- 11. **Bekavac I,** Goel S. (2011). Transient, unilateral, complete, oculomotor palsy in an adult patient with idiopathic intracranial hypertension. **Signa Vitae** 6(1): 44-46.

Abstracts:

- 1. **Bekavac, I.** (1989). Functional correlate between air pollution and heart disease. Medical Conference 35:1989.
- Law Min, J.C., Bekavac, I., Glavinovic, M.I., Donati, F. and Bevan, D.R. (1991). Iontophoretic study of speed of action of various muscle relaxants. Anesthesiology 75:A810.
- 3. **Bekavac, I.** and Waterhouse, B.D. (1992). Physiological actions of cocaine in sensory circuits: I. Enhancement of rat somatosensory cortical neuron responsiveness to vibrisae stimulation. Soc. Neurosci. Abstr. 18:544.
- 4. Waterhouse, B.D. and **Bekavac, I.** (1992). Physiological actions of cocaine in sensory circuits: II. Drug-induced alterations in receptive field properties of rat somatosensory cortical neurons. Soc. Neurosci. Abstr. 18:544.
- 5. Kapural, L., Bekavac, I., Trifaro, J.M. and Glavinovic, M.I. (1992). Effect of 4aminopiridine on bovine chromaffin cell membranes. Soc. Neurosci, Abstr. 18:794.
- 6. Waterhouse, B.D., Stowe, Z., Jimenez-Rivera, C.A. and **Bekavac, I.** (1992). Influences of cocaine on the response properties of single neurons in

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monoaminergically-innervated sensorimotor circuits. Annual Meeting of Drug Abuse, Puerto Rico.

- 7. Waterhouse, B.D. and **Bekavac, I.** (1992). Cocaine effects on stimulus coding properties of sensory cortical neurons. Annual Meeting of Drug Abuse, Puerto Rico.
- Bekavac, I. and Waterhouse, B.D. (1993). Physiological actions of cocaine in sensory circuits: I. Identification of monoaminergic substrates underlying drug-induced enhancement of somatosensory evoked discharges in rat barrel field cortical neurons. Soc. Neurosci. Abstr. 19-1855.
- 9. **Bekavac, I.**, Rutter, J.J. and Waterhouse B.D. (1994). Physiological actions of cocaine in sensory circuits: drug influences on signal transmission through rat Pom and VPM thalamic nuclei. Soc. Neurosci. Abstr. 20:982.
- Bekavac, I., Wallace, R.C., Powers, J., Ratliff, N.B. and Hanna J.P. (1996). Intraarterial thrombolysis of myxomatous proxymal middle cerebral artery occlusion. First Croatian World Congress 1:12.
- 11. **Bekavac, I.,** Hanna, J.P. and Sila, C.A. (1997). Warfarin and low-dose aspirin for stroke prevention in patients with severe large arterial intracranial stenosis failing monotherapy. Neurology, 49:A289
- 12. Bekavac, I., Sethi, P., Wong, C.O. and Hanna, J.P. (1998). Utilizing stress Technetium-99m-ECD brain SPECT in the management of intracranial stenosis. Neurology, 50:A400

BOOK CHAPTERS:

Bekavac I, Pathophysiology of neurological diseases. In: Gamulin S, Marusic M. Pathophysiology, fourth edition, Zagreb: Mladost, 1998:830-860.

LECTURES:

Grand rounds, Cleveland Clinic, May 1998: Excitotoxicity and Stroke Clinical Neuroscience Course, University of Split, June 2000 Clinical Neuroscience Course, University of Split, July 2002



October 30, 2014

RE: William McGrew DOB:

Ivo Bekavac, MD, PhD Dept. of Neurology

753 W. Ridgeway Avenue Suite 112

Waterloo, IA 50701

319.833.5954

FAX 319.833.5955

Mr. William McGrew comes in for followup regarding stroke as well as lower back pain. He had MRI of the lumbosacral spine read by Dr. Halloran, reviewed personally and showed to the patient. It is remarkable for lateral disc herniation at the level L3-L4 as well as disc bulging at the level L3-L4 as well as L4-L5. Dr. Halloran did over read CTA and felt that there is ICA stenosis of 32%. While doing physical therapy he is doing better, also he has been doing stroke rehabilitation. He has not noticed any improvement. On examination, there is a complete weakness involving left upper and left lower extremity 0/5 unchanged since initial examination September 26, 2014. He has been also complaining of being depressed and also noticed by his family as well. List of medications reviewed. He is not taking any antidepressants. Apparently, he is on clopidogrel as well as aspirin 81 mg for stroke prophylaxis.

IMPRESSION:

- 1. Status post right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery. Initial carotid artery stenosis 32% according to Dr. Halloran.
- 2. Intermittent lumbar sensory radiculopathy with symptomatic improvement. No evidence of lumbosacral motor radiculopathy.
- 3. Depression.

PLAN:

- 1. Continue with clopidogrel 75 mg a day as well as aspirin 81 mg a day for secondary stroke prophylaxis.
- 2. Continue physical therapy and stroke rehabilitation.
- 3. Star the patient on Lexapro 10 mg a day for depression. Potential side effects were explained to the patient as well as his family.
- 4. Reevaluate the patient in two months or earlier as needed.
- 5. Multiple questions were answered.

Vo Bekavac, M.D., Ph.D.

IB/ts/wkm

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McGrew, William M (MR # 92371812) DOB: 05/30/1945

Clinical Lab Results (continued)

No matching results found			
	Radiolog	y Results (10/09/14 - 10/01/14)	
	_	jy Results (10/09/14 - 10/01/14)	
y consultation referred		Popultad by:	Resulted: 10/09/14 1426, Result status: Final re
Ordering provider: Performed: Narrative:	Ivo Bekavac, MD 10/01/14 1346 - 10/01/14 1500	Resulted by: Resulting lab:	John I Halloran, MD UPH ALLEN MEMORIAL SUNQUEST RAD
	Allen Memorial Hospital MCGREW,WILLIAM M 1532 HAWTHORNE ST WATERLOO, IA 50702	General X-ray Order No:14ARA24244 PT. LOC: ADMIT HX:	
	MEDICAL RECORD NUMBER: 923	D FIN#: 562501743 OPY TO DR. 71812 DOCUMENT STATUS: Final a:10/01/2014	
	REASON FOR EXAM:visual disturb	ance reading of outside films	
	CONSULTATION/REVIEW OF OUTS	IDE FILMS:	
	I have been consulted to review a CT McGrew at ADI on August 18, 2014. 3-D physician workstation. Volume re projection images were generated and	The examination was reviewed on a ndered and maximum intensity	
	FINDINGS: Aortic arch: Type II aortic arch. Minim aortic arch. Minimal atherosclerosis in carotid artery without a hemodynamic of the right innominate and left subclar	origin of the left common ally significant narrowing. Origin	
	Right carotid: Small focus of calcific at of ICA producing a 32% diameter ster ICA is widely patent.		
	The minimal right ICA diameter measu ICA diameter measures 4.7 cm	res 3.2 cm. Post bulbar normal	
	Left carotid: Heterogeneous atheroscl- producing 22% maximal lumen diame The post bulbar cervical ICA is widely noncalcified moderate stenosis of orig	er stenosis of the proximal ICA. patent. Circumferential	
	The minimal left ICA diameter measur lumen diameter measures 5.4 cm.	es 4.2 mm. Post bulbar normal ICA	
	Vertebrals: Short segmental heterogen producing near occlusive narrowing of artery and focal noncalcific moderate vertebral artery.	the distal right vertebral	
	dso		
	Signed by: John I Halloran MD on 10/9 Report created with Powerscribe 360	9/2014 2:23 PM	
	ALLEN MEMORIAL HOSPITAL, WA MCGREW,WILLIAM M OUTSIDE FILMS FOR REVIEW	TERLOO IA. PAGE 2 of 2 DOCUMENT STATUS: Final	
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Page 709 PLAINTIFFS' EXHIBIT 13

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McGrew, William M (MR # 92371812) DOB: 05/30/1945

Radiology Results (10/09/14 - 10/01/14) (continued)

Xray consultation referred [136743188] (continued)

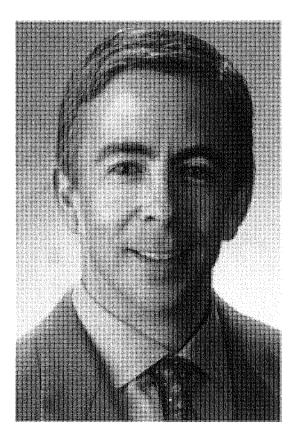
Resulted: 10/09/14 1426, Result status: Final result

Lumbar spine wo co			Resulted: 10/01/14 1459, Result status: Fina			
Ordering provider: Performed: larrative:	Ivo Bekavac, MD 10/01/14 1303 - 10/01/14 1423	Resulted by: Resulting lab:	John I Halloran, MD UPH ALLEN MEMORIAL SUNQUEST RAD			
	Allen Memorial Hospital MRI Depart MCGREW,WILLIAM M Order N 1532 HAWTHORNE ST PT. LO WATERLOO, IA 50702 ADMIT H	lo:14AMR3576 C:				
	PHONE ADMITTING DR: BEKAVAC, IVO MD E ORDERING DR: BEKAVAC, IVO MD F ATTENDING DR: CC: THIS COPY TO D MEDICAL RECORD NUMBER: 92371812 Exam Date:10/01/20: PROCEDURE(S): MR SPINE LUMBAR WO CONTRAST USUAL					
	REASON FOR EXAM:low back pain					
	TECHNIQUE: Multiplanar, multisequence imaging of the lumbar spine performed.					
	CLINCAL HISTORY: see above REASON FOR E					
	CORRELATION: None available. FINDINGS:					
	L1-2 level: Negative L2-3 level: Negative					
	L3-4 level: Slight disc space narrowing. Very broad-based far right lateral disc herniation. Protruding disc fills inferior recess the right neural foramen and closely approximates right L3 nerve. Moderate bilateral degenerative facet arthropathy. Mild spinal canal stenosis. L4-5 level: Moderate bilateral degenerative facet arthropathy, grade I spondylolisthesis, symmetric disc bulge, moderate disc space narrowing and small endplate osteophytes. Mild spinal canal and bilateral neural foraminal stenosis.					
						L5-S1 level: Mild bilateral degenerative facet arthropathy.
	IMPRESSION: 1. L3-4 level far right lateral disc herniation, mild spinal canal stenosis and moderate bilateral degenerative facet arthropathy. 2. L4-5 level degenerative facet arthropathy, spondylolisthesis, and mild spinal canal and bilateral neural foraminal stenosis. Signed by: John I Halloran MD on 10/1/2014 2:56 PM Report created with Powerscribe 360					
						ALLEN MEMORIAL HOSPITAL, WATERLOO I MCGREW,WILLIAM M MR SPINE LUMBAR WO CONTR DOC
	Specimen Collection	Source	Collected On			

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
49 - WLARAD	UPH ALLEN MEMORIAL SUNQUEST RAD	Unknown	Waterloo IA	10/13/13 1803 - Present
Generated on 3/30/20	16 11:42 AM			Page 710

John Halloran, M.D.

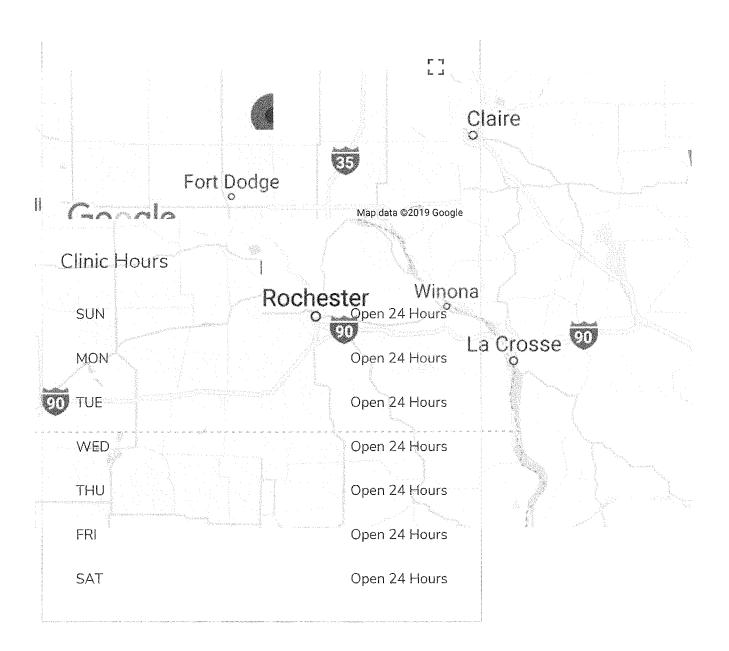


1825 Logan Avenue Waterloo, Iowa 50703

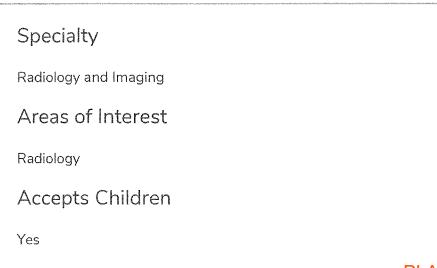
319-235-3941

UnityPoint Health - Allen Hospital

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Professional Summary



PLAINTIFFS' EXHIBIT 13A

College/Medical School

University of Minnesota School of Medicine

Residency

University of Iowa Hospitals and Clinics

Board Certification(s):

American Board of Radiology

Fellowship(s):

University of Iowa Hospitals and Clinics

IN THE DISTRICT COURT OF IOWA IN AND FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW)))
Plaintiffs,)
v.)
EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.)))))))
Defendant.)))

Case No. LACV130355

AFFIDAVIT OF LISA KNIPP

STATE OF IOWA COUNTY OF BUCHANAN

My name is Lisa Knipp. I live in Fairbank, Iowa. I am the daughter of Bill McGrew. After my father suffered a stroke at Allen Memorial Hospital on September 3, 2014, our family talked about getting a second opinion regarding dad's condition to see whether his condition would be permanent and whether there were things that we could do for him that would improve his condition and lifestyle. We got a recommendation for Dr. Ivo Bekavac, a local Neurologist who practices at 1735 W. Ridgeway Ave., Suite 112, Waterloo, Iowa.

We made an appointment for September 26, 2014 and I oversaw gathering up all the medical records that I could get regarding my dad's condition including whatever imaging studies I could get my hands on before the visit. I accompanied my dad to the visit.

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At the visit, we discussed with Dr. Bekavac the history of how my dad had gotten his stroke and the problems that my father was having. During the visit, Dr. Bekavac showed us the CT Angiogram performed on my dad before his surgery. He explained to us that the amount of narrowing in dad's right carotid artery visible on the CT angiogram was not the amount claimed in any of the medical records. My recollection is that the records said something around 65 to 70% narrowing and Dr. Bekavac told us that it was more like 35% narrowing. He also shared with us that he would have the CT angiogram looked at by another physician to confirm his reading of the CT angiogram. Although, based on what he had told us, it was obvious that the CT angiogram had been read incorrectly, Dr. Bekavac told us just that and went on to say that 40% narrowing of my dad's artery was not enough to perform surgery on him. We were very surprised and disappointed to hear that information.

At the end of the visit, we discussed additional care that I do not specifically recall at this time, but which can be found in his progress note. I do recall we discussed a follow-up visit.

At some time later, we learned that the other physician we now know to be Dr. Halloran confirmed Dr. Bekavac's reading. We then received a copy of Dr. Bekavac's progress notes and read through them. It was consistent with what he had told us. Dr. Bekavac has continued to be my father's neurologist to this day.

PLAINTIFFS' EXHIBIT 101

App. 143

I certify under penalty of perjury and pursuant to the laws of the State of Iowa that the preceding is true and correct.

Dated: 12-31-18

Lisa Knipp

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW,)	
,	Ş.	NO. LACV130355
Plaintiffs,)	PLAINTIFF WILLIAM MCGREW'S
vs.)	ANSWERS TO INTERROGATORIES
EROMOSELE OTOADESE, M.D.;)	PROPOUNDED BY DEFENDANT OTOADESE
NORTHERN IOWA CARDIOVASCULAR)	
AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.,)	
F.C., and DRISS CAMMOON, M.D.,)	
Defendants		

COMES NOW Plaintiff William McGrew and hereby submits his Answers to

Interrogatories propounded by Defendant Otoadese in the above case.

Martin A. Diaz 000009676 ICIS AT0002000 1570 Shady Ct NW Swisher, IA 52338 319-339-4350 319-339-4426 fax marty@martindiazlawfirm.com Attorney for Plaintiffs

I certify under penalty of perjury that the following Answers to Interrogatories are true to the best of my knowledge.

Dated: 10-28-16

lion Me Sour

William McGrew

Copy: Counsel of Record

PLAINTIFFS' EXHIBIT 102

16. List the name, address, telephone number, and employer's name, address and telephone number of each person you expect to call as an expert witness (including, but not limited to, practitioners of the healing art) at trial, and with respect to each such individual, state:

- (a) The educational and occupational background of the expert;
- (b) All litigation in which each expert has been consulted or has given a deposition or has testified in trial, including the name and address of the court in which each case was pending, the names of the plaintiffs and defendants in each case, the name and address of the person engaging the services of such expert, the name of the person on whose behalf the expert testified, and whether such person was a plaintiff or defendant in the case;
- (c) The subject matter or area on which each expert will testify;
- (d) The substance of the facts and opinions, and a summary of the grounds for each opinion of each expert named by you in answer to this interrogatory;
- (e) Whether each identified expert has completed preparation for testifying and is ready to express final opinions in this case, or, if the answer is to the contrary, when each expert will have completed preparation and will be ready to express final opinions in this case; and

NOTE: Rule of Civil Procedure 1.508(1)(a) also <u>requires</u> that for an expert retained in anticipation of litigation or for trial the <u>expert shall SIGN the answer</u>. Please comply with this rule.

ANSWER:

Plaintiffs will disclose the names of any retained expert witnesses as part of their designation to the court consistent with the deadline established.

Otherwise, Plaintiff intends to call the following people who were not retained for purposes of this case:

1. One or more members of the staff at New Aldaya Lifescapes Nursing Home, 7511 University Avenue, Cedar Falls, Iowa 50613

2. Dr. John Musgrave, 212 West Dale Street, Waterloo, Iowa 50703

3. Dr. Richard Mauer, Mauer Eye Center, 2515 Cyclone Drive, Waterloo, Iowa 50701

4. Dr. Ivo Bekavac, 1735 W. Ridgeway Ave., Suite 112, Waterloo, Iowa 50701

6. Dr. John Halloran, P O Box 2758, Waterloo, Iowa 50704

7. To the extent needed, any other healthcare provider to discuss evaluation, care and treatment in the past and future for Bill McGrew.

The above individuals can testify to the evaluation, care and treatment of Bill McGrew and can testify to those facts known, mental impressions formed and opinions held as a result of their contact with him. This may include standard of care opinions (as to Dr. Bekavac and Dr. Halloran), causation opinions (Dr. Bekavac), permanency (Dr. Bekavac) and future care and treatment (Dr. Bekavac, New Aldaya, and Dr. Musgrave).

PLAINTIFFS' EXHIBIT 102

IN THE DISTRICT COURT OF IOWA IN AND FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW
Plaintiffs, v.
EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.
Defendant.

Case No. LACV130355

PLAINTIFFS' DESIGNATION OF EXPERTS

COME NOW the Plaintiffs and hereby designate the following persons

who may be called as expert witnesses at the time of trial in the above

referenced matter:

 Dr. Carl Warren Adams 101 Becket Lake Dr. @ Celadon Durango, CO 81301-8853

Dr. Adams is a Board Certified Cardiovascular and Thoracic Surgeon including Trauma and Surgical Critical Care. Dr. Adams will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

Dr. Adams' education, training, experience, and qualifications to testify as an expert witness are set forth in his curriculum vitae which is being provided to counsel. 2. Dr. Ivo Bekavac 1735 W. Ridgeway Ave., Suite 112 Waterloo, Iowa 50701

Dr. Bekavac is a Board Certified Neurologist, with Subspecialty Board Certification in Vascular Neurology and Neuroimaging (among others) who, as a treating physician, will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; the harm sustained by Bill McGrew; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse. He will also be asked to comment on the evaluation, care and treatment he has provided to Bill McGrew since he sustained the stroke on September 2-3, 2014.

Dr. Bekavac's education, training, experience, and qualifications to testify as an expert witness are set forth in his curriculum vitae which has been provided to counsel.

Dr. John Halloran
 1825 Logan Ave.
 Waterloo, Iowa 50701

Dr. Halloran is a Board-Certified Neuroradiologist who will be asked to comment on the evaluation of imaging studies on Bill McGrew that he reviewed at the request of Dr. Bekavac. He will also be asked to comment on the standard of care in the imaging evaluation of an individual like Bill McGrew, any breach of that standard of care, and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse. A professional summary of Dr. Halloran's education, training, experience, and qualifications to testify as an expert witness can be found at the website for UnityPoint Health: <u>www.unitypoint.org/waterloo</u>. A CV may be provided later.

Kent Jayne
 502 Augusta Circle
 North Liberty, Iowa 52317

Mr. Jayne is a Certified Life Care Planner, vocational rehabilitation specialist and an economist who has been asked to develop a life care plan for Bill McGrew and can then testify to the amount of money needed to fund that life care plan. Depending on how the court rules on the issue of a lien for medical expenses, he may be asked to determine what medical bills are related to the injuries and damages sustained by Bill McGrew due to the negligence of the defendants.

Mr. Jayne's education, training, experience, and qualifications are as set forth in his curriculum vitae, which is being provided to counsel.

The following witnesses are "experts" in that they have scientific, technical or other specialized knowledge. However, these individuals (like Dr. Bekavac and Dr. Halloran) have not been retained in anticipation of litigation, and their expert opinions, if any, have not been developed in anticipation of litigation, but rather arise from the fact that these individuals may be treating physicians to the Plaintiff or have such other connection to this litigation that they are fact witnesses with specialized expertise.

5. All of Bill McGrew's treating health care providers as disclosed in the

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discovery process. This includes all individuals disclosed in depositions including the defendants.

6. All other providers of services, assistive devices, educational care, custodial care and rehabilitative care as disclosed in the discovery process.

 Plaintiffs reserve the right to call any other treating health care provider to testify to Bill McGrew's health history and potentially to causation and damages.

8. Plaintiff reserves the right to utilize, as experts, those individuals designated by the defendants in their designation to the Court.

9. Plaintiff reserves the right to call any rebuttal expert witnesses to any expert witness designated by defendants that raise issues otherwise not anticipated or expected.

Respectfully submitted,

MARK L. CHIPOKAS PC

By: <u>/s/ Mark L. Chipokas</u> Mark L. Chipokas, AT0001418 866 First Avenue NE P.O. Box 1261 Cedar Rapids, Iowa 52406-1261 (319) 366-7888 (888) 466-1350 Fax E-mail: mark@mlchipokaspc.com

<u>/s/ Martin A. Diaz</u> Martin A. Diaz 000009676 1570 Shady Ct NW Swisher, IA 52338 phone 319 339 4350 facsimile 319 339 4426 marty@martindiazlawfirm.com Attorneys for Plaintiffs

Copy to all counsel via EDMS

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW,)	
)	NO. LACV130355
Plaintiffs,)	PLAINTIFF WILLIAM MCGREW'S
VS.)	SUPPLEMENTAL ANSWER TO
EROMOSELE OTOADESE, M.D.;)	INTERROGATORY NO. 16 PROPOUNDED BY DEFENDANT
NORTHERN IOWA CARDIOVASCULAR)	OTOADESE (Retained Experts)
AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.,)	
)	
Defendants		

COMES NOW Plaintiff William McGrew and hereby submits his Supplemental

Answer to Interrogatory No. 16 propounded by Defendant Otoadese in the above case.

/s/ Martin A. Diaz

Martin A. Diaz 000009676 ICIS AT0002000 1570 Shady Ct NW Swisher, IA 52338 319-339-4350 319-339-4426 fax marty@martindiazlawfirm.com Attorney for Plaintiffs

Copy: Counsel of Record on March 7, 2018 (with report of Dr. Adams sent on March 8, 2018)

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16. List the name, address, telephone number, and employer's name, address and telephone number of each person you expect to call as an expert witness (including, but not limited to, practitioners of the healing art) at trial, and with respect to each such individual, state:

- (a) The educational and occupational background of the expert;
- (b) All litigation in which each expert has been consulted or has given a deposition or has testified in trial, including the name and address of the court in which each case was pending, the names of the plaintiffs and defendants in each case, the name and address of the person engaging the services of such expert, the name of the person on whose behalf the expert testified, and whether such person was a plaintiff or defendant in the case;
- (c) The subject matter or area on which each expert will testify;
- (d) The substance of the facts and opinions, and a summary of the grounds for each opinion of each expert named by you in answer to this interrogatory;
- (e) Whether each identified expert has completed preparation for testifying and is ready to express final opinions in this case, or, if the answer is to the contrary, when each expert will have completed preparation and will be ready to express final opinions in this case; and

NOTE: Rule of Civil Procedure 1.508(1)(a) also <u>requires</u> that for an expert retained in anticipation of litigation or for trial the <u>expert shall SIGN the answer</u>. Please comply with this rule.

ANSWER:

Plaintiffs will disclose the names of any retained expert witnesses as part of their designation to the court consistent with the deadline established.

Otherwise, Plaintiff intends to call the following people who were not retained for purposes of this case:

2

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1. One or more members of the staff at New Aldaya Lifescapes Nursing Home, 7511 University Avenue, Cedar Falls, Iowa 50613

2. Dr. John Musgrave, 212 West Dale Street, Waterloo, Iowa 50703

3. Dr. Richard Mauer, Mauer Eye Center, 2515 Cyclone Drive, Waterloo, Iowa 50701

4. Dr. Ivo Bekavac, 1735 W. Ridgeway Ave., Suite 112, Waterloo, Iowa 50701

6. Dr. John Halloran, P O Box 2758, Waterloo, Iowa 50704

7. To the extent needed, any other healthcare provider to discuss evaluation, care and treatment in the past and future for Bill McGrew.

The above individuals can testify to the evaluation, care and treatment of Bill McGrew and can testify to those facts known, mental impressions formed and opinions held as a result of their contact with him. This may include standard of care opinions (as to Dr. Bekavac and Dr. Halloran), causation opinions (Dr. Bekavac), permanency (Dr. Bekavac) and future care and treatment (Dr. Bekavac, New Aldaya, and Dr. Musgrave).

SUPPLEMENT TO INTERROGATORY 16 PURSUANT TO IRCP 1.500(2)(b)

Dr. Carl Warren Adams 101 Becket Lake Dr. @ Celadon Durango, CO 81301-8853

(a) Please refer to his CV previously produced.

(b) Please refer to the list of cases previously provided

(c) Dr. Adams is a Board Certified Cardiovascular and Thoracic Surgeon including Trauma and Surgical Critical Care. Dr. Adams will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; and the cause-andeffect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

(d) Attached is the report from Dr. Adams.

(e) Dr. Adams is generally ready to be deposed. However, he will be given the opportunity to read the deposition of Dr. Otoadese and Dr. Cammoun, if taken, before he is deposed.

3

Kent Jayne 502 Augusta Circle North Liberty, Iowa 52317

(a) Please refer to his CV previously produced.

(b) Please refer to the list of cases previously provided

(c) Mr. Jayne is a Certified Life Care Planner, vocational rehabilitation specialist and an economist who has been asked to develop a life care plan for Bill McGrew and can then testify to the amount of money needed to fund that life care plan. Depending on how the court rules on the issue of a lien for medical expenses, he may be asked to determine what medical bills are related to the injuries and damages sustained by Bill McGrew due to the negligence of the defendants.

(d) Attached is the report from Mr. Jayne. Please also see the "Handicapped Accessibility Updates to Home" provided by Magee Construction Company which was provided to Mr. Jayne after he prepared his report.

(e) Mr. Jayne is prepared to be deposed. However, he may be review additional information as Mr. McGrew's condition is permanent and he requires constant care.

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW,)	
)	NO. LACV130355
Plaintiffs,)	PLAINTIFF WILLIAM MCGREW'S
VS.)	SUPPLEMENTAL ANSWER TO
EROMOSELE OTOADESE, M.D.;)	INTERROGATORY NO. 16 PROPOUNDED BY DEFENDANT
NORTHERN IOWA CARDIOVASCULAR)	OTOADESE (Treating Physicians)
AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.,)	
)	
Defendants		

COMES NOW Plaintiff William McGrew and hereby submits his Supplemental

Answer to Interrogatory No. 9 propounded by Defendant Otoadese in the above case.

/s/ Martin A. Diaz_

Martin A. Diaz 000009676 ICIS AT0002000 1570 Shady Ct NW Swisher, IA 52338 319-339-4350 319-339-4426 fax marty@martindiazlawfirm.com Attorney for Plaintiffs

Copy: Counsel of Record on March 7, 2018

E-FILED 2019 FEB 14 10:10 AM BLACKHAWK - CLERK OF DISTRICT COURT

16. List the name, address, telephone number, and employer's name, address and telephone number of each person you expect to call as an expert witness (including, but not limited to, practitioners of the healing art) at trial, and with respect to each such individual, state:

- (a) The educational and occupational background of the expert;
- (b) All litigation in which each expert has been consulted or has given a deposition or has testified in trial, including the name and address of the court in which each case was pending, the names of the plaintiffs and defendants in each case, the name and address of the person engaging the services of such expert, the name of the person on whose behalf the expert testified, and whether such person was a plaintiff or defendant in the case;
- (c) The subject matter or area on which each expert will testify;
- (d) The substance of the facts and opinions, and a summary of the grounds for each opinion of each expert named by you in answer to this interrogatory;
- (e) Whether each identified expert has completed preparation for testifying and is ready to express final opinions in this case, or, if the answer is to the contrary, when each expert will have completed preparation and will be ready to express final opinions in this case; and

NOTE: Rule of Civil Procedure 1.508(1)(a) also <u>requires</u> that for an expert retained in anticipation of litigation or for trial the <u>expert shall SIGN the answer</u>. Please comply with this rule.

ANSWER:

Plaintiffs will disclose the names of any retained expert witnesses as part of their designation to the court consistent with the deadline established.

Otherwise, Plaintiff intends to call the following people who were not retained for purposes of this case:

2

E-FILED 2019 FEB 14 10:10 AM BLACKHAWK - CLERK OF DISTRICT COURT

1. One or more members of the staff at New Aldaya Lifescapes Nursing Home, 7511 University Avenue, Cedar Falls, Iowa 50613

2. Dr. John Musgrave, 212 West Dale Street, Waterloo, Iowa 50703

3. Dr. Richard Mauer, Mauer Eye Center, 2515 Cyclone Drive, Waterloo, Iowa 50701

4. Dr. Ivo Bekavac, 1735 W. Ridgeway Ave., Suite 112, Waterloo, Iowa 50701

6. Dr. John Halloran, P O Box 2758, Waterloo, Iowa 50704

7. To the extent needed, any other healthcare provider to discuss evaluation, care and treatment in the past and future for Bill McGrew.

The above individuals can testify to the evaluation, care and treatment of Bill McGrew and can testify to those facts known, mental impressions formed and opinions held as a result of their contact with him. This may include standard of care opinions (as to Dr. Bekavac and Dr. Halloran), causation opinions (Dr. Bekavac), permanency (Dr. Bekavac) and future care and treatment (Dr. Bekavac, New Aldaya, and Dr. Musgrave).

SUPPLEMENT TO INTERROGATORY 16 PURSUANT TO IRCP 1.500(2)(c)

Dr. John Musgrave, Dr. Matthew Smith, Dr. Richard Mauer, Dr. Ivo Bekavac, and Dr. John Halloran may testify pursuant to previously produced medical records and Plaintiff's Designation of Experts, filed February 6, 2018.

Dr. Bekavac will testify as to the standard of care, causation, and permanency. In his medical record dated September 26, 2014, Dr. Bekavac reviewed the CTA and determined a stenosis of the right ICA of approximately 40%. 40% stenosis is not sufficient to justify endarterectomy. The first and therefore the second endarterectomy were unnecessary and violated the standard of care. Dr. Bekavac is a Board Certified Neurologist, with Subspecialty Board Certification in Vascular Neurology and Neuroimaging (among others) who, as a treating physician, will be asked to comment on the standard of care in the evaluation (imaging and surgery), care and treatment of an individual like Bill McGrew; the breach of that standard of care; the harm sustained by Bill McGrew; and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse. He will also be asked to comment on the evaluation, care and treatment he has provided to Bill McGrew since he sustained the stroke on September 2-3, 2014.

Dr. Halloran, in his medical record dated October 9, 2014, reviewed the CTA and assessed a stenosis of 32%. Dr. Cammoun and Dr. Otoadese misread the CTA and

3

PLAINTIFFS' EXHIBIT 105

violated the applicable standard of care. Dr. Halloran is a Board-Certified Neuroradiologist who will be asked to comment on the evaluation of imaging studies on Bill McGrew that he reviewed at the request of Dr. Bekavac. He will also be asked to comment on the standard of care in the imaging evaluation of an individual like Bill McGrew, any breach of that standard of care, and the cause-and-effect relationship between the breach of the standard of care and any damages and injuries sustained by Bill McGrew and his spouse.

Dr. Musgrave may be asked to testify about Bill McGrew's medical history before and after his stroke and his care and treatment of Bill McGrew.

Dr. Maurer may be asked to testify about his care and treatment of Bill McGrew.

Dr. Smith has provided handwritten responses to questions propounded by Kent Jayne and those responses are part of the report prepared by Mr. Jayne. In addition, Dr. Smith may be asked to testify to his care and treatment of Bill McGrew.

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE MCGREW,)	
)	NO. LACV130355
Plaintiffs,		PLAINTIFF WILLIAM MCGREW'S
vs.)	SUPPLEMENTAL ANSWERS TO
EROMOSELE OTOADESE, M.D.;)	INTERROGATORIES PROPOUNDED BY DEFENDANT
NORTHERN IOWA CARDIOVASCULAR)	OTOADESE
AND THORACIC SURGERY CLINIC, P.C.; and DRISS CAMMOUN, M.D.,		
	/	
Defendants		

COMES NOW Plaintiff William McGrew, by counsel, and hereby submits his

Supplemental Answers to Interrogatories propounded by Defendant Otoadese in the

above case.

/s Martin A. Diaz Martin A. Diaz 000009676

ICIS AT0002000 1570 Shady Ct NW Swisher, IA 52338 319-339-4350 319-339-4426 fax marty@martindiazlawfirm.com Attorney for Plaintiffs

Copy: Counsel of Record sent by email on December 18, 2018.

(a) Yes. Plaintiff began to receive Medicare when he turned age 65. His Medicare claim number is but he also has a United Healthcare AARP number for insurance (ID # is but he also has a United Healthcare but he

- (b) N/A
- (c) N/A
- (d) N/A
- (e) N/A
- (f) Yes, but it has not yet produced a printout.

SUPPLEMENTAL ANSWER:

(f) Please refer to the most recent printout provided to counsel.

25. State with particularity the basis of your liability claim against these Defendants. Identify with specificity each and every negligent act (fault) and the name and address of each witness who will support the claim.

ANSWER:

Plaintiffs refer the defense to the Petition. Plaintiffs may supplement after taking the depositions of facts witnesses and disclosures of experts.

SUPPLEMENTAL ANSWER:

Please refer to the medical records from Allen Memorial Hospital, the records from Drs. Bekavac and Halloran, the expert disclosures and the deposition of Dr. Adams. The specifications of negligence are as follows:

Regarding Dr. Cammoun:

1. Failing to correctly interpret the amount of stenosis in the right internal carotid artery.

Regarding Dr. Otoadese:

1. Performing a right carotid endarterectomy on September 2, 2014 on an asymptomatic patient;

2. Failing to correctly interpret the amount of stenosis in the right internal

PLAINTIFFS' EXHIBIT 106

App. 161

carotid artery;

3. Failing to investigate the length of time that the patient had signs or

symptoms of a stroke on September 3, 2014; and

4. Failing to take Mr. McGrew promptly back to surgery after he learned that Mr. McGrew was having signs or symptoms of a stroke on September 3, 2014.

Marty Diaz

From:	George Weilein < GWeilein@wbpclaw.com>
Sent:	Monday, November 26, 2018 8:54 AM
То:	Marty Diaz; JER@ShuttleworthLaw.com
Cc:	mark@mlchipokaspc.com; Barb Helmlinger; JMILLER@ShuttleworthLaw.com
Subject:	Re: McGrew v. Cammoundefense expert depositions

I join in Jennifer's e-mail on behalf of Dr. Cammoun.

George

>>> Jennifer Rinden <JER@ShuttleworthLaw.com> 11/25/2018 5:18 PM >>> Marty -

Sorry for the delayed response - I have been out of the office on other matters. I was the one who initially requested the depositions of Drs. Halloran and Bekavac. Upon further reflection, I do not believe these depositions are necessary. Neither of these doctors have expressed standard of care opinions and will not be allowed to do so given the fact we have not been provided a written report from either. Further, Halloran is not even a treater, let alone a retained expert, and I intend to file a motion in limine to exclude any reference to him as completely irrelevant to these proceedings.

As for your request for our experts, I have asked Barb to check with Drs. Levett and Gebel to see what might work. I have two trials in December and another 2 week trial in January. By necessity, these depositions will be toward the end of January at the earliest. As you know, the first word I had of your interest in these depositions was November 14. We will do what we can to get these scheduled but given the timing of the request and my schedule, the options will be limited. George will respond concerning the availability of his expert.

Thanks - Jennifer

Sent from my iPad

On Nov 20, 2018, at 10:48 AM, Marty Diaz <Marty@martindiazlawfirm.com<mailto:Marty@martindiazlawfirm.com>> wrote:

[EXTERNAL EMAIL]

I understand that you are both busy, but I would like to confirm the deposition date and time for Drs. Halloran and Bekavac, and would like to schedule in the depositions of your experts. Please see my email below.

Thanks.

Marty

Martin A. Diaz 1570 Shady Ct NW Swisher, IA 52338 (319) 339-4350 Fax: (319) 339-4426 marty@martindiazlawfirm.com<mailto:marty@martindiazlawfirm.com>

From: Marty Diaz <Marty@martindiazlawfirm.com<mailto:Marty@martindiazlawfirm.com>> Sent: Wednesday, November 14, 2018 7:33 AM To: Mark Chipokas <mark@mlchipokaspc.com<mailto:mark@mlchipokaspc.com>>; George Weilein <GWeilein@wbpclaw.com<mailto:GWeilein@wbpclaw.com>>

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Cc: JER@ShuttleworthLaw.com<mailto:JER@ShuttleworthLaw.com>; JMILLER@ShuttleworthLaw.com<mailto:JMILLER@ShuttleworthLaw.com>; Marty Diaz <Marty@martindiazlawfirm.com<mailto:Marty@martindiazlawfirm.com>> Subject: RE: McGrew v. Cammoun--defense expert depositions

Jennifer and George-

Now that we have scheduled the depositions of our remaining experts for January 21 or 22, I would like to schedule the depositions of all defense experts. I want to take Dr. Hawk in person in California, so please provide dates when you are both available. I would imagine that no more than 1.5 hours for Dr. Hawk should be enough.

I also want to take Dr. Levett's deposition in person in Cedar Rapids. If we take the depositions of Drs. Halloran and Bekavac on either January 21 or 22, we can take the deposition of Dr. Levett on the other date. I will need no more than 1.5 hours for him.

I am willing to take Dr. Gebel's deposition by videoconference. I will need no more than 1.5 hours for him.

Please let me know what dates work for both of you for all these depositions.

Thanks.

Marty

Martin A. Diaz 1570 Shady Ct NW Swisher, IA 52338 (319) 339-4350 Fax: (319) 339-4426 marty@martindiazlawfirm.com<mailto:marty@martindiazlawfirm.com>

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

)	
MCGREW,)	NO. LACV130355
Plaintiffs,)	
)	PLAINTIFFS' WITNESS LIST, LIST
VS.)	OF EXHIBITS AND DESIGNATION
)	OF DEPOSITION PORTIONS
EROMOSELE OTOADESE, M.D. and)	
NORTHERN IOWA CARDIOVASCULAR)	
AND THORACIC SURGERY CLINIC,)	
P.C.)	
)	
Defendants		

COMES NOW the Plaintiff and advises the court and Defendant of his list of

prospective Exhibits for the upcoming trial and requests that Defendant provide

designations as to the admissibility of these exhibits:

WITNESS LIST

In addition to the Plaintiffs, the Plaintiffs anticipate calling the following witnesses:

- 1. Lisa Knipp, daughter of Plaintiffs.
- 2. Michelle McGrew, daughter of the Plaintiffs.
- 3. Melanie Bird, daughter of the Plaintiffs.
- 4. Troy McGrew, son of the Plaintiffs.
- 5. Linda Morgan, neighbor.
- 6. Kyle Larson, friend of Bill
- 7. Dr. Richard Mauer, Opthalmologist
- 8. Dr. Ivo Bekavac, Neurologist
- 9. Dr. John Halloran, Neuroradiologist

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- 10. Dr. Carl Adams, Durango, CO
- 11. Allyson Landphair, ARNP
- 12. Aubrey Donlea, PCT at Allen Memorial Hospital
- 13. Rachel Havens, RN at Allen Hospital
- 14. Dr. Otoadese
- 15. Kent Jayne, North Liberty
- 16. Claire Boyle, Social Worker at New Aldaya

Plaintiffs reserve the right to call the following possible witnesses:

- 1. All persons disclosed during discovery.
- 2. All rebuttal witness.
- 3. All foundation witnesses.
- 4. All witnesses declared by Defendants.
- 5. Any expert designated by Defendants.

EXHIBIT NUMBER	DESCRIPTION OF EXHIBIT	DEFENDANT'S DESIGNATION
1	Dr. Mauer: plan note and ophthalmology chart note for July 25, 2014 for Bill McGrew	
2	Dr. Mauer: request for Ultrasound and addendum with results of Ultrasound	
2A	Ultrasound report of August 6, 2014	
3	Informed Consent for Cataract Surgery for August 20, 2014	
4	Dr. Otoadese: Initial Visit of August 18, 2014	
5	Dr. Cammoun: report of CT angiogram of August 18, 2014	
6	Dr. Mauer: telephone message canceling cataract surgery	
7	Dr. Otoadese: Second visit of August 20, 2014	
8	Operative report of September 2, 2014	
9	Discharge summary for September 2, 2014 admission authored by Ms. Landphair	
10	Dr. Otoadese: encounter note for October 2, 2014	
11	Dr. Bekavac: progress note for September 26, 2014	
11A	Dr. Bekavac: CV	
12	Dr. Bekavac: progress note for October 30, 2014	
13	Dr. Halloran: imaging reports for October 1, 2014	
13A	Dr. Halloran: Resume or qualifications	
14	September 2, 2014 surgery timeline	
15	Nurse Borrett: significant event note for September 3, 2014 at 7:20 AM	
16	Select Nursing flowsheets for September 3, 2014	
17	Dr. Almullahassani: Consultation notes in September 2014	
18	Operative report of September 3, 2014	
19A	Reports: CT and MRI of Head between 849am and 932am on September 3, 2014	
19B	Reports: CT Angiogram at 1245pm on September 3, 2014	
19C	Reports: MR Angiogram and MRI Brain at 1031am on September 4, 2014	

EXHIBIT LIST

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20	Dr. Manshadi: Consultation report of September 5, 2014	
21	Gastroenterology Notes and Operative report for Endoscopy on September 8, 2014	
22	Dr. Almullahassani: Consultation report of January 26, 2015	
23	Dr. Smith: Progress note of September 21, 2018	
24	Dr. Bekavac: all other progress notes and relevant records	
25	Diagram prepared by Dr. Cammoun	
25A	Diagram prepared by Dr. Otoadese	
26	Dr. Otoadese: other relevant medical records	
27	Dr. Musgrave: progress notes for 8-27-14 and 9-30-14	
28	Dr. Inamdar: consultation report of November 6, 2014	
29	Mayo Clinic: select records	
30	New Aldaya: select records	
31-34	Photos before his injuries	
35	Photos taken Friday before surgery and day of surgery	
36	Photo of McGrew Home exterior	
37	Photo of McGrew backyard	
38	Photo of McGrew garage	
39	Photos at McGrew Home Interior	
39A-B	Photos of golf at Beaver Hills on 8.29.14	
40	Report of Kent Jayne	
40A	Kent Jayne: Report from Dr. Smith	
40B	Kent Jayne: CV	
41	Dr. Adams: CV	
42-50	Reserved for other exhibits and demonstrative aids. This includes a calendar (July to October 2014) and possible medical illustrations.	

AMENDED DESIGNATION OF DEPOSITION PORTIONS

Pursuant to IRCP 1.704(2), Plaintiffs will designate 5 separate portions from the deposition of Dr. Otoadese. The first will be shown by videotape to the jury and relates to Dr. Otoadese's qualifications. The remaining 4 portions will be read into the record in the presence of the jury throughout the trial and deal with different aspects of the medical care and treatment of Mr. McGrew. Pursuant to Iowa Rule 1.705(1), Defendant is requested to offer any other part of the deposition "relevant to the portion offered." Plaintiffs request that any additional portions be provided at least 10 days before trial so that any video editing can be performed. If not provided by then, Plaintiff will only show that portion of the video designated and will read into the record any other relevant portion.

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	Page 7, L. 1	Page 7, L. 25
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Page 23, L. 8	Page 23, L. 25
Page 24, L. 1	Page 24, L. 18
Page 24, L. 1	Page 24, L. 18

DEPONENT	BEGINNING PAGE AND LINE	ENDING PAGE AND LINE
DR. OTOADESE #2 (Read) Events of September 3, 2014	Page 37, L. 25	
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DEPONENT	BEGINNING PAGE AND LINE	ENDING PAGE AND LINE
DR. OTOADESE #3 (Read) August 18, 2014 Visit	Page 58, L. 9	Page 58, L.25

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DEPONENT	BEGINNING PAGE AND LINE	ENDING PAGE AND LINE
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DEPONENT	BEGINNING PAGE AND LINE	ENDING PAGE AND LINE
DR. OTOADESE #5 (Read) Informed Consent	Page 95, L. 3	Page 95, L.25
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Respectfully submitted,

/s/ Martin A. Diaz Martin A. Diaz 000009676 ICIS AT0002000 1570 Shady Ct NW Swisher, IA 52338 phone 319 339 4350 facsimile 319 339 4426 marty@martindiazlawfirm.com Attorney for Plaintiff

MARK L. CHIPOKAS PC

By: /s/ Mark L. Chipokas Mark L. Chipokas, AT0001418 866 First Avenue NE P.O. Box 1261 Cedar Rapids, Iowa 52406-1261 (319) 366-7888 (888) 466-1350 Fax E-mail: mark@mlchipokaspc.com

copy: Per EDMS

1	IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY
2	
3	WILLIAM MCGREW and) ELAINE MCGREW,)) NO. LACV130355
4	Plaintiffs,)
5	vs.) Videotaped
6) Deposition of EROMOSELE OTOADESE,)
7	M.D.; NORTHERN IOWA) EROMOSELE OTOADESE, CARDIOVASCULAR AND) M.D. THORACIC SURGERY)
8	CLINIC, P.D., and) DRISS CAMMOUN, M.D.,
9) Defendants.)
10	
11	
12	
13	Videotaped Deposition of EROMOSELE
14	OTOADESE, M.D., taken before Julie M. Kluber,
15	Certified Shorthand Reporter, commencing at
16	9:32 a.m., March 8, 2018, at 515 Main Street,
17	Suite E, Cedar Falls, Iowa.
18	
19	
20	
21	
22	
23	Julie M. Kluber, CSR, RMR
24	3515 Lochwood Drive NE Cedar Rapids, IA 52402 319-286-1717
25	1-866-412-4766

1	<u>APP</u>	PEARANCES
2 3	Plaintiffs by:	MARTIN A. DIAZ Attorney at Law 1570 Shady Court NW Swisher, IA 52338
4		and MARK L. CHIPOKAS
5		Attorney at Law 866 First Avenue NE
6		P.O. Box 1261 Cedar Rapids, IA 52406-1261
7	Defendants Otoadese	•
8	and Northern Iowa Cardiovascular and	VINCENT S. GEIS Attorneys at Law
9	Thoracic Surgery Clinic by:	115 Third Street SE, Suite 500 P. O. Box 2107
10		Cedar Rapids, IA 52406-2107
11	Defendant Cammoun by:	GEORGE L. WEILEIN Attorney at Law
12	<i></i>	515 Main Street, Suite E P. O. Box 724
13		Cedar Falls, IA 50613
14	Videographer:	Josh Goding
15		
16		
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21	22	11-16-16 statement from NIA	
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24	24	Dr. Otoadese's hand-drawn	05
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		4			6
1		PROCEEDINGS	1	Α.	I did Yeah, I did I did graduate work in
2		THE VIDEOGRAPHER: Good morning. We're on	2		biochemistry.
3		the record at 9:32 a.m., March 8, 2018, at the	3	Q.	So you were a student, then, the entire time
4		law offices of Weilein and Boller, P.C., in	4		or
5		Cedar Falls, Iowa.	5	Α.	Yes.
6		EROMOSELE OTOADESE, M.D.,	6	Q.	only part of that time?
7		called as a witness, having been first duly	7		No. I was a student the whole time.
8		sworn, testified as follows:	8	Q.	So when you came to the United States in 1971,
9		DIRECT EXAMINATION	9		did you come to go to college or or was it
10		BY MR. DIAZ:	10		high school or what was that?
11	Q.	Doctor, could you please introduce yourself by	11	Α.	I finished high school in Costa Mesa in
12		providing us with your full name.	12		California, then went to college.
13	Α.	Anthony Eromosele Otoadese.	13	Q.	Okay. So pretty much from when you came to the
14		All right. And I understand you like to go by	14		U.S. in 1971 up until 1987, when you start
15		Dr. Tony?	15		medical school, you are you're a student.
16	Α.	Yes.	16		Correct?
17	Q.	Okay. Doctor, in front of you is a document	17	A.	Yes. Graduate student, yes.
18		marked Exhibit 1, which is my understanding	18		Right. Both high school, undergrad, graduate,
19		is this is your c.v. that was provided to us.	19		and now you're going to go to medical school.
20		Can you look at it and let me know if this is	20	A.	Medical school, yes.
21		up to date.	21		Okay. And then you're in medical school up
22	Α.	Yes, it is.	22	-	until 1987, and then from there you do your
23		Okay. My understanding is you were born in	23		residency, your fellowship I'm sorry, your
24	-	Nigeria?	24		internship, your residency, and then
25	Α.	Yes.	25		fellowships that take you all the way up to
		5			7
1	Q.	5 And what year did you come to the	1		7 1996. Correct?
1 2	Q.	And what year did you come to the	1	A.	1996. Correct?
1 2 3			1 2 3		1996. Correct? Yes. Correct.
2	A.	And what year did you come to the United States? 1971.	2		1996. Correct? Yes. Correct. So essentially you're a student from 1971 up
2 3	A. Q.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.?	2 3	Q.	1996. Correct? Yes. Correct.
2 3 4 5	A. Q. A.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study.	2 3 4	Q. A.	1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes.
2 3 4 5 6	A. Q. A.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first	2 3 4 5 6	Q. A.	1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to Iowa is you do
2 3 4 5 6 7	A. Q. A. Q.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971?	2 3 4 5 6 7	Q. A.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to lowa is you do your fellowship at the University of lowa
2 3 4 5 6 7 8	A. Q. A. Q.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971? I wanted to go to college to get an education	2 3 4 5 6 7 8	Q. A. Q.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to lowa is you do your fellowship at the University of lowa Hospitals and Clinics.
2 3 4 5 6 7 8 9	A. Q. A. Q.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971? I wanted to go to college to get an education first. I wanted to do sociology in college,	2 3 4 5 6 7 8 9	Q. A. Q. A.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to Iowa is you do your fellowship at the University of Iowa Hospitals and Clinics. Yes, I did.
2 3 4 5 6 7 8 9 10	A. Q. Q. A.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971? I wanted to go to college to get an education first. I wanted to do sociology in college, but I ended up majoring in chemistry.	2 3 4 5 6 7 8 9 10	Q. A. Q. A.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to lowa is you do your fellowship at the University of lowa Hospitals and Clinics. Yes, I did. Okay. Now, have you done any additional
2 3 4 5 6 7 8 9 10 11	A. Q. Q. A.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971? I wanted to go to college to get an education first. I wanted to do sociology in college, but I ended up majoring in chemistry. Okay. My understanding is you went to the	2 3 4 5 6 7 8 9 10 11	Q. A. Q. A.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to lowa is you do your fellowship at the University of lowa Hospitals and Clinics. Yes, I did. Okay. Now, have you done any additional education other than what we see up through
2 3 4 5 6 7 8 9 10 11 12	A. Q. Q. A.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971? I wanted to go to college to get an education first. I wanted to do sociology in college, but I ended up majoring in chemistry. Okay. My understanding is you went to the University of California at Santa Cruz and you	2 3 4 5 6 7 8 9 10 11 12	Q. A. Q. A. Q.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to Iowa is you do your fellowship at the University of Iowa Hospitals and Clinics. Yes, I did. Okay. Now, have you done any additional education other than what we see up through 1996?
2 3 4 5 6 7 8 9 10 11 12 13	A. Q. Q. A.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971? I wanted to go to college to get an education first. I wanted to do sociology in college, but I ended up majoring in chemistry. Okay. My understanding is you went to the University of California at Santa Cruz and you got a degree in 1978.	2 3 4 5 6 7 8 9 10 11 12 13	Q. A. Q. A. Q.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to lowa is you do your fellowship at the University of lowa Hospitals and Clinics. Yes, I did. Okay. Now, have you done any additional education other than what we see up through 1996? As far as you mean college education or
2 3 4 5 6 7 8 9 10 11 12 13 14	A. Q. Q. A. Q. A.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971? I wanted to go to college to get an education first. I wanted to do sociology in college, but I ended up majoring in chemistry. Okay. My understanding is you went to the University of California at Santa Cruz and you got a degree in 1978. Yes.	2 3 4 5 6 7 8 9 10 11 12 13 14	Q. A. Q. A. Q.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to Iowa is you do your fellowship at the University of Iowa Hospitals and Clinics. Yes, I did. Okay. Now, have you done any additional education other than what we see up through 1996? As far as you mean college education or or specialty training? I don't understand what
2 3 4 5 6 7 8 9 10 11 12 13 14 15	A. Q. Q. A. Q. A. Q.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971? I wanted to go to college to get an education first. I wanted to do sociology in college, but I ended up majoring in chemistry. Okay. My understanding is you went to the University of California at Santa Cruz and you got a degree in 1978. Yes. And a chemistry major?	2 3 4 5 6 7 8 9 10 11 12 13 14 15	Q. A. Q. A. Q.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to Iowa is you do your fellowship at the University of Iowa Hospitals and Clinics. Yes, I did. Okay. Now, have you done any additional education other than what we see up through 1996? As far as you mean college education or or specialty training? I don't understand what the question is.
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	A. Q. Q. A. Q. A. Q.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971? I wanted to go to college to get an education first. I wanted to do sociology in college, but I ended up majoring in chemistry. Okay. My understanding is you went to the University of California at Santa Cruz and you got a degree in 1978. Yes. And a chemistry major? Chemistry, yes.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	Q. A. Q. A. Q.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to Iowa is you do your fellowship at the University of Iowa Hospitals and Clinics. Yes, I did. Okay. Now, have you done any additional education other than what we see up through 1996? As far as you mean college education or or specialty training? I don't understand what the question is. Sure. So your c.v. takes us all the way up to
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	A. Q. Q. A. Q. A. Q.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971? I wanted to go to college to get an education first. I wanted to do sociology in college, but I ended up majoring in chemistry. Okay. My understanding is you went to the University of California at Santa Cruz and you got a degree in 1978. Yes. And a chemistry major? Chemistry, yes. Okay. And then the next thing that I have on	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	Q. A. Q. A. Q.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to Iowa is you do your fellowship at the University of Iowa Hospitals and Clinics. Yes, I did. Okay. Now, have you done any additional education other than what we see up through 1996? As far as you mean college education or or specialty training? I don't understand what the question is. Sure. So your c.v. takes us all the way up to 1996, and my understanding is that you start
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	A. Q. A. Q. A. Q. A. Q.	And what year did you come to the United States? 1971. And for what purpose did you come to the U.S.? To study. And what did you want to study when you first came in 1971? I wanted to go to college to get an education first. I wanted to do sociology in college, but I ended up majoring in chemistry. Okay. My understanding is you went to the University of California at Santa Cruz and you got a degree in 1978. Yes. And a chemistry major? Chemistry, yes. Okay. And then the next thing that I have on your c.v. is that you then went to medical school at the State University of New York Downstate in Brooklyn and got your medical degree in 1987. Yes.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q. A. Q. A. Q. A.	 1996. Correct? Yes. Correct. So essentially you're a student from 1971 up until 1996. Yes. Okay. And the way you get to Iowa is you do your fellowship at the University of Iowa Hospitals and Clinics. Yes, I did. Okay. Now, have you done any additional education other than what we see up through 1996? As far as you mean college education or or specialty training? I don't understand what the question is. Sure. So your c.v. takes us all the way up to 1996, and my understanding is that you start working, then, in Waterloo in around 1996? Yes. I finished This is the only job I ever had. I finished, I took a job here, and I've been here since then. Okay. And what I'm interested in knowing is in

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8

1 A. Over the years, yes. I -- You know, I got

T	А.	Over the years, yes. I Tou know, I you			
2		into interventional vascular surgery and I took			
3		training in this.			
4	Q.	So what's interventional vascular work? What			
5		is that?			
6	Α.	Interventional endovascular procedures, using			
7		balloons and stents to supplement, to			
8		complement the open surgeries that I do.			
9	Q.	Okay. So up through 1996 in terms of your			
10		training, was your training limited to open			
11		type procedures?			
12	Α.	Open, yes.			
13		And did you start learning endovascular work?			
14		After that.			
15	Q.	After that.	15	Q.	My understanding is that practically all of
16		Right.	16		your hospital work is at Allen Memorial
17		Okay. And do you list that anywhere on your	17		Hospital. Is that right?
18		c.v.?	18	A.	Yes, yes.
19	A.	No, you don't I don't need to. Just	19		I think at one time you said it was 99 percent
20		It's just not I didn't get diplomas or	20		of your work?
21		anything from it, so	21	A.	Yeah. I would say that, yeah.
22	Q.	Or certificates?			, , , , , , , , , , , , , , , , , , ,
23		No certificates, no.			
24		Well, when you			
25		They're meetings. You go to meetings. Some of			
		9	† –	-	
1		them a week, some of them two weeks. Hands-on			
2		experience and things, yeah.			
3	Q.	Okay. And			
4		I did that.			
			21	0	Okay. And my understanding that once you
			21	α.	finished your training at University Hospitals
			22		and went into private practice, you came to
			23		Waterloo and you you were with one
			24		Traterioo and you you wore with one

25

particular -- I want to call it a clinic. I

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l	2

		12			14
1		don't know what you would what you called it	1	Α.	Um-hmm. Yes.
2		back then, but there were it was you and a	2	Q.	And then my understanding is in 2013, you open
3		couple of other colleagues that ran a a	3		up Northern Iowa Cardiovascular and Thoracic
4		clinic. What was the name of that clinic?	4		Surgery Clinic, P.C.
5	Α.	I'm trying to remember. Cardiac Surgery	5	Α.	Yes, I did.
6		Associates or something like that, yes.	6	Q.	Okay. And actually, the records show that you
7	Q.	Right. And then at some point Cardiac Surgery	7		formally created the company in November of
8		Associates merges with Cedar Valley Medical	8		2012. Is that is that about right?
9		Specialists, Professional Corporation.	9	Α.	Yes, yes.
10		Correct?	10	Q.	In anticipation that you're going to start
11	Α.	Right. It wasn't a merger, but but we we	11		January 1 of 2013. Correct?
12		joined them. We we were asked to join them	12	Α.	I don't remember the dates. Yes.
13		because the cardiologists at the hospital were	13	Q.	And it's true, isn't it, that you were
14		part of Cedar Valley. We were independent and	14		terminated from Cedar Valley Medical
15		Dr. John Wiggins, he was the senior partner.	15		Specialists? I think you described it as they
16		He had hired me. He didn't want to join Cedar	16		kicked you out. Is that correct?
17		Valley, he wanted to be independent, but the	17	Α.	Correct, yes.
18		cardiologists who we work very closely with	18	Q.	Okay. Now, I want to talk about the kind of
19		were part of Cedar Valley, so the hospital	19		work that you've done since you started in
20		administrator said it's it's easier and	20		started in private practice in roughly 1996.
21		works better if when the surgeons and the	21		We talked about you doing open procedures.
22		cardiologists are in the same group. So we	22	Α.	Yes.
23		were made to join them politically, and that's	23	Q.	And endovascular work.
24		one reason John left.	24	Α.	Yes.
25	Q.	Okay. And then my understanding is you were at	25	Q.	So I want to understand the difference. So
		13			15
1		Coder Valley Madical Crossialists from 1000			
		Cedar Valley Medical Specialists from 1999	1		when you talk about open procedures, what are
2		until 2012 through 2012.	1 2		when you talk about open procedures, what are we talking about there?
	A.			A.	we talking about there? Open surgery where you you open up. An
2		until 2012 through 2012. Yes. Okay. And as part of that, are you considered	2	A.	we talking about there? Open surgery where you you open up. An example would be an abdominal aortic aneurysm.
2 3		until 2012 through 2012. Yes. Okay. And as part of that, are you considered a partner? A shareholder? A member? What	2 3	A.	we talking about there? Open surgery where you you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular
2 3 4		until 2012 through 2012. Yes. Okay. And as part of that, are you considered a partner? A shareholder? A member? What was what was the relationship within that	2 3 4	A.	we talking about there? Open surgery where you you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular methods, you it was done open method where
2 3 4 5	Q.	until 2012 through 2012. Yes. Okay. And as part of that, are you considered a partner? A shareholder? A member? What was what was the relationship within that organization?	2 3 4 5	A.	we talking about there? Open surgery where you you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular
2 3 4 5 6	Q.	until 2012 through 2012. Yes. Okay. And as part of that, are you considered a partner? A shareholder? A member? What was what was the relationship within that organization? Cedar Valley Medical Specialists is a group of	2 3 4 5 6	A.	we talking about there? Open surgery where you you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular methods, you it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced
2 3 4 5 6 7	Q.	until 2012 through 2012. Yes. Okay. And as part of that, are you considered a partner? A shareholder? A member? What was what was the relationship within that organization? Cedar Valley Medical Specialists is a group of specialists. I think we were 23 specialties	2 3 4 5 6 7	A.	we talking about there? Open surgery where you you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular methods, you it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced it with a graft. But with the endovascular
2 3 4 5 6 7 8	Q.	until 2012 through 2012. Yes. Okay. And as part of that, are you considered a partner? A shareholder? A member? What was what was the relationship within that organization? Cedar Valley Medical Specialists is a group of specialists. I think we were 23 specialties and 55 surgeons, and if I remember correctly,	2 3 4 5 6 7 8	A.	we talking about there? Open surgery where you you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular methods, you it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced it with a graft. But with the endovascular procedure, we can less invasive so that you're
2 3 4 5 6 7 8 9	Q.	until 2012 through 2012. Yes. Okay. And as part of that, are you considered a partner? A shareholder? A member? What was what was the relationship within that organization? Cedar Valley Medical Specialists is a group of specialists. I think we were 23 specialties and 55 surgeons, and if I remember correctly, when you first joined you're not a shareholder	2 3 4 5 6 7 8 9	A.	we talking about there? Open surgery where you you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular methods, you it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced it with a graft. But with the endovascular procedure, we can less invasive so that you're able to do them without opening the abdomen.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17	Q. A. Q.	until 2012 through 2012. Yes. Okay. And as part of that, are you considered a partner? A shareholder? A member? What was what was the relationship within that organization? Cedar Valley Medical Specialists is a group of specialists. I think we were 23 specialties and 55 surgeons, and if I remember correctly, when you first joined you're not a shareholder but after two years or something you become a shareholder. Okay. I've seen documents from the secretary of state that show that in 2012, the last year that you were there, that there were 58 different physicians that were part of Cedar Valley Medical Specialists. Yes.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	Q. A.	we talking about there? Open surgery where you you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular methods, you it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced it with a graft. But with the endovascular procedure, we can less invasive so that you're able to do them without opening the abdomen. You could do percutaneous, for example. You go through the groin without making incisions and you put a stent in the aneurysm. That's endovascular. Okay. And my understanding is that you were doing as part of the open procedures, you're doing open what you call open heart surgery. Yes.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q. A. Q. A. Q.	 until 2012 through 2012. Yes. Okay. And as part of that, are you considered a partner? A shareholder? A member? What was what was the relationship within that organization? Cedar Valley Medical Specialists is a group of specialists. I think we were 23 specialties and 55 surgeons, and if I remember correctly, when you first joined you're not a shareholder but after two years or something you become a shareholder. Okay. I've seen documents from the secretary of state that show that in 2012, the last year that you were there, that there were 58 different physicians that were part of Cedar Valley Medical Specialists. Yes. Okay. And that they included Dr. Bekavac, Dr. Halloran, Dr. Cammoun Yes. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	Q. A.	 we talking about there? Open surgery where you you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular methods, you it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced it with a graft. But with the endovascular procedure, we can less invasive so that you're able to do them without opening the abdomen. You could do percutaneous, for example. You go through the groin without making incisions and you put a stent in the aneurysm. That's endovascular. Okay. And my understanding is that you were doing as part of the open procedures, you're doing open what you call open heart surgery. Yes. And I know that some folks don't necessarily use that term "open heart" the way that maybe a layperson might understand it. Can you tell us
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Q. A. Q. A. Q. A. Q. A.	 until 2012 through 2012. Yes. Okay. And as part of that, are you considered a partner? A shareholder? A member? What was what was the relationship within that organization? Cedar Valley Medical Specialists is a group of specialists. I think we were 23 specialties and 55 surgeons, and if I remember correctly, when you first joined you're not a shareholder but after two years or something you become a shareholder. Okay. I've seen documents from the secretary of state that show that in 2012, the last year that you were there, that there were 58 different physicians that were part of Cedar Valley Medical Specialists. Yes. Okay. And that they included Dr. Bekavac, Dr. Halloran, Dr. Cammoun Yes. and you. Yes. 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Q. A.	 we talking about there? Open surgery where you you open up. An example would be an abdominal aortic aneurysm. For a long time before the endovascular methods, you it was done open method where you open up the abdominal wall, got in the abdomen and cut the aneurysm out and replaced it with a graft. But with the endovascular procedure, we can less invasive so that you're able to do them without opening the abdomen. You could do percutaneous, for example. You go through the groin without making incisions and you put a stent in the aneurysm. That's endovascular. Okay. And my understanding is that you were doing as part of the open procedures, you're doing open what you call open heart surgery. Yes. And I know that some folks don't necessarily use that term "open heart" the way that maybe a layperson might understand it. Can you tell us what that would have consisted of, what you
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	16		vi.D.	18
1	A. Heart surgery. Valve replacement, coronary	1		him you finish your answer and then let him
2	artery bypass grafting, aneurysm resection.	2		finish, Marty.
3	You open the chest.	3	Α	If you insist that I go into it, it was a
4	Q. Okay. Now, if you If somebody were to come	4	7	political thing, and and I wasn't I
5	to you today and say, "I want to do open	5		wasn't in agreement with with with things
6	heart" "I want you to do an open heart	6		and I sued the hospital, and that resulted in a
7	surgery," would you be able to do that on them?	7		lot other things. All I can tell you is that I
, 8	A. I could but I don't do them anymore. I stopped	8		am still in good standing in the hospital. I
9	doing open heart in 2009.	9		do all my surgeries there. I I mean I'm
10	Q. I think you've testified in the past that you	10		still on the on the hospital staff in good
11	stopped doing open heart surgeries in 2008 and	11		standing.
12	that you	12	Q.	Okay. So just to summarize, there was some
13	A. Okay.	13	ά.	sort of disagreement between you and the
14	Q voluntarily surrendered your privileges to	14		hospital that related to doing open heart
15	do open heart surgeries.	15		surgeries. Your viewpoint is that there was a
16	A. Yes, I did.	16		political decision. Correct?
17	Q. Okay. And that my understanding is that that	17	Α.	Correct.
18	was at the insistence of the hospital. Is that	18		It ended up in you filing a lawsuit with some
19	true?	19		kind of a settlement that's confidential.
20	A. No.	20		Correct?
21	Q. That's not true?	21	Α.	Correct.
22	A. No.	22	Q.	Okay. All right. The fact is that you've not
23	Q. All right. So it was your desire all along to	23		done open heart surgeries, then, since roughly
24	just stop doing open heart surgeries in 2008,	24		2008, 2009. Is that true?
25	2009?	25	Α.	2009, yes.
	17			19
1	MS. RINDEN: Well, hold on. I'm going to	1	Q.	Okay. Now, my understanding from looking at
2	object to the form. Argumentative.	2		things you've said in the past that you were
3	You can answer, Doctor, if you can.	3		doing in this timeframe of roughly 1999 to
4	A. Yes. It's I I don't know if it's	4		2008 I'm going to use that timeframe you
5	something to be discussed here, but it was	5		were doing 50 to 60 percent of all surgeries
6	political, and and it even resulted in a	6		were open heart surgeries, 30 to 40 percent
7	lawsuit and was settled out of court, but it	7		were vascular surgeries, and 10 to 20 percent
8	wasn't it wasn't that straightforward. It	8		was thoracic. Is that true?
9	was political, yes.	9		Noncardiac thoracic.
10	Q. I understand the concept of political, but	10	Q.	Okay. So I want to understand what we're
11	the but the true answer to my question when	11		talking about. So up until you have this
12	I said that the hospital insisted that you stop	12		this disagreement with the hospital
13	doing them, that that is technically true.	13		Yes.
14	Correct?	14	Q.	2008, 2009, you're doing about 50 to 60
15	A. Not correct. It's not.	15		percent of your work is doing open heart
16	Q. So the hospital didn't ask you to stop doing	16		surgeries.
17	open heart surgeries?	17		I would say so, yes.
18	A. They did not they did not ask I did not	18	Q.	Okay. And about 30 to 40 percent is vascular,
19	stop doing open heart surgery because they	19		so what is vascular then?
20	asked you to.	20	Α.	Peripheral vascular, working on arteries and
21	Q. They told you to.	21	~	veins.
22	A. It was negotiated.	22	Q.	So in this case with Mr. McGrew where you end
23		23		up doing a carotid endarterectomy, what is
	MS. RINDEN: Hold on a minute. You guys	24		that? In that a vacaular propodure?
24 25	are talking at the same time, and I'm going to	24	٨	that? Is that a vascular procedure?
24 25	•••	24 25	A.	that? Is that a vascular procedure? Vascular. Page 16 to 19

PLAINTIFFS' EXCERPT #1

Page 16 to 19

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		20			22
1	Q.	Okay. And then 10 to 20 percent would be	1	Α.	Because we were doing them about 300 300
2		noncardiac thoracic.	2		two-eighty to 300 hearts, open hearts a year.
3		Yes.	3		They just take longer.
4		Meaning what?	4		Yes.
5	Α.	Lungs, esophagus, you know, anything in the	5	Q.	And so for that reason, 50 percent, 60 percent
6	_	chest other than heart.	6		of your time may be a more appropriate way
7	Q.	Okay. In this timeframe before you stopped	7		rather than saying 50, 60 percent of your
8		doing the open heart surgeries, when you did	8		surgeries.
9		vascular work, what percentage of your vascular	9		Well, yeah. Yes, I agree with that.
10		work was open and what percentage was	10	Q.	Okay. All right. Now, you have testified in
11	^	endovascular?	11		the past that despite your being fired from
12	А.	I can't I can't guess. I can't I can't	12		Cedar Valley Medical Specialists in 2012 that
13		guess. I think most of it was open. But I	13		you maintained, quote, "a good working
14	0	can't give you percentage.	14	^	relationship with those folks."
15	Q.	In reading what you've testified in the past	15	А.	Yes.
16		about, I got the impression that you were far			
17		more comfortable doing open procedures than you were doing endovascular. Is that a fair			
18		statement?			
19 20	٨	In the in the beginning, yes, because the			
20	А.	open was what I was trained doing.			
21	0	Right.			
22		But I'd say learned more endovascular and got			
23	л.	better in it, and I'm just as comfortable doing			
25		endovascular now.			
		21	+ -		-
1	Q	Okay. All right. And so that we get an idea			
2	۹.	of how many surgeries you would do, all types,			
3		in this timeframe before your disagreement with			
4		Allen Hospital, how many surgeries do you think			
5		you would do in a year's time?			
6		MS. RINDEN: I'm going to object to the			
7		form. You can go ahead and answer, Doctor.			
8	Α.	Yes. I would say until again, I can't put	8	Q.	Okay. But and I don't want to be unfair to
9		numbers in it, but all I can tell you that I	9		you, Doctor.
10		was the only cardiovascular surgeon in the	10	Α.	Okay.
11		Cedar Valley up until 2008 or so, so I did all	11	Q.	I used the word "fired" as the equivalent of
12		the open heart surgeries. I did most of the	12		"terminated." You used the word This is
13		vascular surgeries and most of the thoracic	13		what you said. You said, "They terminated me
14		surgeries.	14		They kicked me out."
15	Q.	Are you able to give me a reasonable estimate	15	Α.	That's what I'm saying. I'm just clarifying
16		of the number of surgeries you would do in a	16		that.
17		year back then?	17	Q.	And I appreciate that. I appreciate that. Did
18	Α.	At one point I was doing over 1,000.	18		you have any for example, did you get along
19	Q.	Okay. All right. So if you're losing 50 to 60	19		with Dr. Bekavac?
20		percent of your open heart work, does that mean	20		Yes. I still do, yes.
21		500 to 600 of those surgeries were lost,	21	Q.	Okay. Do you get along with Dr. Halloran?
22		meaning you're no longer doing them, or is it	22		Yes. I still do.
23		not that simple?	23	Q.	Okay. Is there anyone at Cedar Valley with
24		It's not that simple.	24		whom you did not have a good working
25	Q.	Okay.	25		relationship when you left in 2012?

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- 1 A. Working relationship, no. I get along with
- 2 everybody.
- 3 Q. Okay. All right. As you sit here, I know
- 4 you're aware that Dr. Bekavac has written --
- 5 he's got a medical record that talks about his
- 6 viewpoint of what happened with Mr. McGrew. I
- 7 assume you've had a chance to look at that?
- 8 A. Yes, I have.
- 9 Q. Okay. And I assume you've seen Dr. Halloran's
- 10 interpretation of the CT angiogram done on
- 11 Mr. McGrew on August 18th of 2014?
- 12 A. Yes, I have.
- 13 Q. I assume you disagree with both of them.
- 14 A. Yes, I do.
- 15 Q. Okay. Do you have an explanation for why
- 16 they've taken the position that they've taken?
- 17 A. No, I can't -- I can't second-guess them. I
- don't -- you know.

PLAINTIFFS' EXCERPT #1

App. 181

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE	
MCGREW,	
Plaintiffs,)) NO. LACV130355
vs.	
EROMOSELE OTOADESE, M.D.; and NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.,) DEFENDANTS' OBJECTIONS TO) PLAINTIFFS' DEPOSITION) DESIGNATIONS)
Defendants	

Defendants Dr. Eromosele Otoadese and Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. provide the following objections to Plaintiffs' depositions designations:

Part 1: All designated testimony from pages 11:21-24:18.

In the Deposition at page 11:21 and through 24:18, the subjects generally include background information pre-dating this case, including the circumstances under which Dr. Otoadese left a prior professional clinic (Cedar Valley Specialists) which involved a lawsuit, settlement, and issues of liability insurance; circumstances under which Dr. Otoadese stopped doing open heart surgery (a type of surgery that is not at issue in this case) at Allen Hospital which involved a lawsuit, settlement, and privileging issues; Plaintiffs' speculative theory that Dr. Otoadese was financially motivated to recommend surgery to Mr. McGrew; a suggestion that Dr. Otoadese is not "comfortable" doing endovascular surgery; Dr. Otoadese's working relationship with Dr. Bekavac and Dr. Halloran -- intended to bolster the credibility of those physicians in the eyes of the jury; and seeking speculative testimony as to why Dr. Bekavac and Dr. Halloran would disagree with Dr. Otoadese.

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These subjects and this deposition testimony should be excluded. They are completely irrelevant and non-probative to the issues the jury will decide, are unsupported by Plaintiffs' expert as in anyway connected to the alleged medical negligence, and would be incurably prejudicial to Dr. Otoadese. They are collateral issues that would waste the Court and jury's time and create suspicions, doubts, and potential hostilities towards Dr. Otoadese. Further, the only way Defendants could adequately respond to the evidence would only compound the prejudice. Even if minimally probative (which Defendants do not concede), the likelihood of unfair prejudice far exceeds the probative value of these subjects.

This evidence should be excluded under Rules 5.402, 5.403, 5.408, 5.411, Defendants' Motion in Limine ¶4 (b) (c) (e) (g); ¶5 (lawsuits), ¶6 (privileging), ¶9 (insurance), ¶12 (settlement); Plaintiff's First Motion in Limine ¶4 (other litigation); Plaintiffs' Second Motion in Limine ¶8 (opinions about credibility of others).

In addition there is inadmissible hearsay in these pages. See Rule 5.802. Hearsay in these sections includes: the conduct of Cedar Valley Specialists of terminating, firing, or "kicking Dr. Otoadese out" (14:13-17, 23:11-16) and Allen Hospital's alleged "insistence" that Dr. Otoadese give up his privileges for open heart surgery or that it "told" him to (16:17-19, 17:11-21).

Part 2:

Line 41:7-17: Rule 5. 802 (hearsay)

Line 42:23-43:9 (through "I said no."): Hearsay (5.802); speculation

Line 44:9-45:10: Hearsay and related to hearsay

Part 3: All testimony designated in lines 58:9 through 64:16.

Deposition 58:9-60:6 is related to the recommendation of an "open" surgery or stenting. This is not relevant to any issue the jury will decide. There are no expert criticisms of Dr.

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Otoadese recommending an open procedure. This is only offered to either suggest a financial motive or that Dr. Otoadese is somehow not as qualified as he should be. *See* Rule 5. 402, 5.403; Defendants' motion in limine ¶4(e).

Deposition 63:4-64:16 relates to dictation and documentation practices. No expert opines on these issues as in anyway remotely related to anything. They are not. Rules 5.402, 5.403.

Part 4: All testimony designated 66:17 through 73:3.

This testimony concerns Dr. Otoadese not ordering a second ultrasound, implying it was because of lack of reimbursement for Dr. Otoadese's own lab. 66:17-68:23. Plaintiffs' expert does not opine there should have been a repeat ultrasound. Dr. Otoadese testified he did not need one given he ordered a CT angiogram. This subject has no relevance and is only designated to suggest financial concerns controlled Dr. Otoadese's decisions. It is wishful thinking, speculation and fabrication. *See* Rule 5.402, 5.403, Defendants' motion in limine ¶4(e)

At Deposition 70:21-72:3, Plaintiffs' counsel asked questions about ultrasound interpretation to which Dr. Otoadese put no weight and did not know how its values were created. Plaintiffs' counsel proceeds to testify about "a society for ultrasound techs that put together sort of values . . .". Whatever Plaintiffs seek to accomplish, it is not relevant. Plaintiffs' expert Dr. Adams does not offer any criticism of Dr. Otoadese based upon the ultrasound. *See* Rules 5.402, 5. 403. It is also in the form of a hypothetical with no basis in fact and is inadmissible on this basis as well. *See Hubby v. State*, 331 N.W.2d 690, 696 (Iowa 1983) ("The facts assumed in a hypothetical question must be supported by the evidence in the record.").¹

¹ "It is well established in this jurisdiction, as well as elsewhere, that where the record is lacking in any evidence proving or tending to prove the assumed facts, the hypothetical question is improper." *State v. Tharp*, 138 N.W.2d 78, 83 (Iowa 1965); *id.* at 84 (finding improper hypothetical that was not supported by the evidence was prejudicial, could not be cured by an instruction, and required reversal; "where there was no evidence to support the question, we think the properly objected-to opinion created such prejudicial testimony that it could not be erased by such an instruction to disregard. The poison could not be thus neutralized.").

Part 5: Lines 99:22-100:3.

In this testimony, Dr. Otoadese was asked if he told Dr. McGrew about a 20% risk of not doing surgery. But this is *not* Plaintiffs' informed consent claim. Instead, Plaintiffs' informed consent claim--assuming without conceding it is admissible--is that Dr. Otoadese did not give information as an alternative medication therapy assuming surgery was necessary. See Rules 5. 402, 5.403.

II. General Objections.

a. Plaintiffs should not be allowed to introduce Dr. Otoadese's deposition and also call him as a witness in their case.

Plaintiffs list Dr. Otoadese as a trial witness but it is unclear if they are calling him live or by deposition. Defendants object if Plaintiffs intend to call Dr. Otoadese in their case in chief in addition to showing/reading portions of his deposition. Plaintiffs should only be allowed one or the other: call Dr. Otoadese as a witness or show/read those portions of his depositions allowed by the Court—not both.

For witnesses who are available in court to testify and who will testify in court, showing or reading deposition testimony serves to emphasize that testimony. It is likely to also include repetitive testimony—further emphasizing it. A live witness may not testify repeatedly. The opportunity for repetition and emphasis does not exist for live witnesses or witnesses for whom there is no deposition. Deposition testimony should be treated no differently than a live trial witness—the jury should hear from the witness once in the party's case.

As to the portion of the deposition Plaintiffs intend to show by video, it is even more important that it be shown once and not repeated by live testimony. "Videotaped testimony may seem more believable or important to the lay jury because it can both see and hear the witness. .

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. . Repeatedly showing the same few deposition segments seems to exalt the relevance of those videotaped shreds of evidence over live testimony. "*Hynix Semiconductor Inc. v. Rambus Inc.*, 2008 WL 190990 * 1 (N.D. Cal. Jan. 21, 2008); *see also Bannister v. Town of Noble*, 812 F.2d 1265, 1269 (10th Cir. 1987) (acknowledging "dominating nature of film evidence" as a "legitimate concern;" discussing concern that jury will give greater weight to film).

b. Plaintiffs should not be allowed to show or read deposition excerpts in segments "throughout trial" but the allowed portions of the deposition should be shown and read in one setting.

Plaintiffs designate portions of Dr. Otoadese's deposition in five separate sections and suggest the sections will be shown and read "into the record . . . throughout the trial." Defendants object to showing and reading the deposition in isolated segments. All portions of Dr. Otoadese's deposition that is allowed over defense objections should be shown/read in one setting.

A party may not call a live witness to testify repeatedly—picking and choosing subjects to cover in isolated segments "throughout trial." Nor should Plaintiffs be allowed to do this via a deposition. Allowing Plaintiffs to use deposition testimony in selected excerpts "throughout the trial" will serve to give that testimony undue emphasis and increase the likelihood it will be taken out of context from the witnesses' entire testimony. Such segments will be separated in time from the remainder of the witness' testimony and any cross examination. Rule 5.106 provides that when a party introduces part of a statement, the adverse party may require introduction "at that time" of any other part "that in fairness ought to be considered at the same time." Plaintiffs should be required to show or read whatever portions of Dr. Otoadese's deposition is allowed in one setting to avoid undue emphasis and unfair prejudice.

c. Using deposition excerpts during voir dire or during opening statements.

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Defendants object to any use of deposition excerpts during voir dire or opening

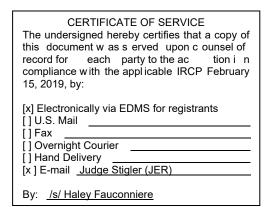
statements. Such use would be unfairly prejudicial to Defendants, emphasizing the testimony by means of mere repetition. A live witness may not testify repeatedly. Depositions should be treated no differently. *See Wyatt Technology Corp. v. Malvern Instruments, Inc.*, 2010 WL

11505684 *22 (C.D. Cal., 2010) (precluding use of videotaped depositions in opening statements as the "lay jury would put undue weight on that testimony" given it may be shown multiple times "in the exact same form."); *Id* ("[O]pening arguments is not the time to play excerpts of video-taped depositions."); *see also In re C.R. Bard, Inc., Pelvic Repair Sys. Prod. Liab. Litig.*, 2013 WL 3282926 *8 (S.D.W. Va. 2013) (subsequent history on other matters omitted) (precluding the parties from using video deposition clips during opening statements).

/s/ Jennifer E. Rinden JENNIFER E. RINDEN AT0006606 for SHUTTLEWORTH & INGERSOLL, P.C. 500 U.S. Bank Bldg., P.O. Box 2107 Cedar Rapids, IA 52406 PHONE: (319) 365-9461 FAX: (319) 365-9461 FAX: (319) 365-8443 e-mail: jer@shuttleworthlaw.com ATTORNEYS FOR EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.

cc: Martin A. Diaz, Esq. 1570 Shady Ct NW Swisher, IA 52338

> Mark L. Chipokas, Esq. Mark L. Chipokas, P.C. 866 First Avenue N.E. P.O. Box 1261 Cedar Rapids, IA 52406-1261



Honorable George Stigler Black Hawk County Courthouse 316 East 5th Street P.O. Box 9500 Waterloo, IA 50704-9500 E-mail: <u>George.stigler@iowacourts.gov</u>

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE)
MCGREW,	
) NO. LACV130355
Plaintiffs,	
) PLAINTIFFS' RESISTANCE
vs.) TO OBJECTIONS TO
) DEPOSITION DESIGNATIONS
EROMOSELE OTOADESE, M.D.;	
and NORTHERN IOWA	
CARDIOVASCULAR AND	
THORACIC SURGERY CLINIC,	
P.C.	
Defendants	

COME NOW the Plaintiffs and in resistance to the Objections filed by Defendants to Plaintiffs' Deposition Designations state:

Part 1: This excerpt relates to Dr. Otoadese's qualifications as a physician and surgeon.¹ Defendants have already filed a motion in limine relating to this issue and plaintiffs have filed a resistance to that motion. For the court's convenience, plaintiffs will restate that argument and then provide additional comments to the objections filed:

Dr. Otoadese has testified that in 2008-2009 he "voluntarily" surrendered his hospital privileges to perform heart surgery, which at the time constituted 50-60% of his overall time performing surgeries. Dr. Otoadese then filed suit against Allen

¹ It is noteworthy that Defendants have marked Dr. Otoadese's CV as proposed Exhibit K.

Memorial Hospital relating to these surrendered privileges and reached a confidential settlement unknown to these Plaintiffs. (*See Otoadese v. Allen Memorial Hospital*, Black Hawk County, LACV114625). But, notwithstanding that settlement, Dr. Otoadese has not performed "open heart" surgeries since 2009. He has admitted that at the time he was performing "open heart" surgeries, they constituted 50-60% of his surgery time and approximately 30% of his overall surgeries.

In 2012, Dr. Otoadese was "kicked out" (terminated)² from Cedar Valley Medical Specialists and on January 1, 2013 he opened Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. In the summer of 2014, Dr. Otoadese's surgeries were limited to vascular and nonvascular thoracic areas of the body and he was still not performing open-heart procedures---consistent with the fact that he no longer had privileges to perform open heart surgeries.

One of Dr. Otoadese's experts is Dr. James Levett, a cardio thoracic surgeon from Cedar Rapids. Dr. Levett was retained as an expert witness by Allen Hospital in the lawsuit filed by Dr. Otoadese. Dr. Levett was hired to testify to the

² These are Dr. Otoadese's words. He explains in his deposition that he was terminated because CVMS was not able to get insurance to cover his practice. Plaintiffs do not know if that is an accurate reflection of why, but they do not intend to offer that evidence unless the defendant wishes to.

appropriateness of the decision to withhold surgical privileges from Dr. Otoadese to perform open-heart procedures.

The above facts are undisputed.

It is also undisputed that on August 18, 2014, Mr. McGrew went to see Dr.

Otoadese who recommended surgery and did not discuss with Mr. McGrew

alternative treatment for his condition that did not require surgery.

A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue.

Iowa Rule of Evidence 5.702

Iowa law existing at the time this case was filed, Iowa Code §147.139,

provided as follows:

If the standard of care given by a physician....is at issue, the court shall only allow a person to qualify as an expert witness and to testify on the issue of the appropriate standard of care if the person's medical...qualifications relate directly to the medical problem or problems at issue and the type of treatment administered in the case.

Dr. Otoadese will testify in his own defense. Dr. Otoadese is an expert

witness and he will testify to the fact that he did not violate the standard of care. In order to assess Dr. Otoadese's credibility as an expert, the court must provide the plaintiff the opportunity to question Dr. Otoadese's qualifications including any

limitations on his hospital privileges, and the successes and failures that he has had

as a physician and surgeon. This includes any motivation that he may have had to

perform surgery on Mr. McGrew. The evidence will include the fact that his surgical practice had taken a substantial downturn in 2009 when he was not allowed to perform open-heart procedures. The evidence will also include the fact that his surgical practice was significantly affected by his termination ("kicked out", as he termed it) from Cedar Valley Medical Specialists. In order to properly assess Dr. Otoadese's skill as a physician and his motive for recommending surgery, the jury needs to be given all relevant information. Failure to provide the jury with that information would mislead the jury.

If Dr. Otoadese were called as a retained expert, plaintiffs would be permitted to inquire about the hospital privileges maintained by him and whether he had ever been terminated from a clinical group. That information would be relevant to assess his qualifications to render standard of care opinions.

In addition to the undisputed facts regarding his hospital privileges at Allen Memorial Hospital, and his termination from Cedar Valley Medical Specialists, there is the additional evidence that one of Dr. Otoadese's expert witnesses has previously testified as an expert witness against Dr. Otoadese in the case involving his privileges to perform open-heart procedures at Allen Memorial Hospital.

This inquiry into the qualifications of any expert, including a defendant who was an expert, has been recognized by the Iowa Supreme Court:

We are committed to a liberal rule on admissibility of expert testimony, *Wick v. Henderson*, 485 N.W.2d 645, 648 (Iowa 1992), and the admission of

such testimony rests within the sound discretion of the district court. *Tappe v. Iowa Methodist Medical Ctr.*, 477 N.W.2d 396, 402 (Iowa 1991). Iowa Rule of Evidence 702 has "codified Iowa's existing liberal rule on the admission of opinion testimony." *Hutchison v. American Family Mut. Ins. Co.*, 514 N.W.2d 882, 885 (Iowa 1994). The United States Supreme Court reaffirmed this approach in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 125 L. Ed. 2d 469, 113 S. Ct. 2786, 2799, 125 L. Ed. 2d 469, 485 (1993). Rule 702 provides:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.

Further, in its comments to rule 702, the advisory committee stated:

If [pursuant to Iowa Rule of Evidence 104(a)] *the Court is satisfied that the threshold requirements have been met, the witness should be allowed to testify.* **All further inquiry regarding the extent of his** [or her] qualifications go to the weight that the fact finder can give such testimony under Rule 104(e).

Carolan v. Hill, 553 N.W.2d 882, 888 (Iowa 1996) (Italics in original; bold added)

In Hutchison v. American Family Mut. Ins. Co., 514 N.W.2d 882 (Iowa

1994), the plaintiff objected to testimony from defendant's retained expert because

he was not board certified in neuropsychology and because he was a psychologist

and not a medical doctor testifying about medical causation. In rejecting this

objection, the court took pains to point out that the ultimate assessment of

qualifications was left to the trial process including cross-examination and jury

assessment of the witness. The court stated:

Dr. Moore has board certification as a clinical psychologist, holds a Ph.D. in clinical psychology, and has substantial experience in neuropsychology. Although Dr. Moore lacked board certification in neuropsychology, we believe this fact went to the weight of his testimony, not its admissibility.

Although few of these restrictions on experts strike us as fundamentally unsound, we refuse to impose barriers to expert testimony other than the basic requirements of Iowa rule of evidence 702 and those described by the Supreme Court in *Daubert*. The criteria for qualifications under rule 702-knowledge, skill, experience, training, or education--are too broad to allow distinctions based on whether or not a proposed expert belongs to a particular profession or has a particular degree.

We understand the concern that expert testimony regarding the causes of personal injury can fall "wholly in the realm of conjecture, speculation, and surmise." Nevertheless, we agree with the *Daubert* Court that the trial court in its discretion and the jury in its deliberation provide the most effective determination of the admissibility and weight of expert psychological testimony.

Similarly, we believe with the aid of vigorous cross examination, the jury is fully capable of detecting the most plausible explanation of events.

Moreover, plaintiffs had ample opportunity to discredit Dr. Moore. Plaintiffs' counsel subjected Dr. Moore to *thorough cross examination regarding his qualifications* and the basis of his testimony, *placing special emphasis on his lack of medical qualifications*....

Id. at 886-889 (Italics added)

Finally, in Andersen v. Khanna, 913 N.W.2d 526 (Iowa 2018), the Court

held that the personal characteristics of a physician may establish a duty of

disclosure as part of obtaining informed consent for treatment. In discussing the

duty to disclose surgical experience, the Court noted the following:

Indeed, at trial several experts testified regarding the number of Bentall procedures they had performed and their training to perform the procedure in

order to establish their competency to testify as expert witnesses. *It stands to reason that if such information is relevant to establishing a witness's expertise, such information could be material to a reasonable patient's decision to or not to undergo a particular treatment.*

Id. at 540 (emphasis added).

The Court cited with approval a Louisiana Court of Appeals decision that "held the physician had a duty to disclose his chronic alcohol abuse." *Andersen* at 542 (citing to *Hidding v. Williams*, 578 So. 2d 1192, 1196 (La. Ct. App. 1991)). The Court makes clear that the qualifications of a physician may be relevant to consent, and in the process highlights that a physician's history is important in assessing their credibility.

Defendants contend that permitting evidence of the qualifications of the defendant physician would be more prejudicial than probative. However, it would be more prejudicial not to tell the jury about the qualifications and working history of this physician. Under what circumstances is the qualifications of an expert physician not probative? Under what circumstances is the working history of an expert physician not probative? They clearly are. If prejudice exists, it does so because defendant's qualifications create such prejudice. It is not prejudice created by the plaintiffs. If any such prejudice exists, it cannot outweigh the probative value of a jury understanding a physician's qualifications.

Additional comments:

1. In their Objections, Defendants make the following statement: "the circumstances under which Dr. Otoadese left a prior professional clinic (Cedar Valley Specialists) *which involved a lawsuit, settlement, and issues of liability insurance*." (Objections, p.1)

Plaintiffs are not aware of any lawsuit or settlement arising out of the termination of Dr. Otoadese from the practice at Cedar Valley Medical Specialists. While Dr. Otoadese claimed that the reason he was "kicked out" was because he was uninsurable, plaintiffs do not intend to show that part of his answer.

2. Defendants contend that the use of the word "termination" or "kicked out" are hearsay. Both terms have been used by Dr. Otoadese in a prior deposition and are therefore his words and not the words of a third party. He endorsed those terms in this deposition. His own words are not hearsay but rather are admissions. The same applies to any description of his disagreement with Allen Hospital. He responded to questions regarding how one would interpret the decision to have him stop performing cardiac surgery.

3. While plaintiffs do not intend to go into other lawsuits filed <u>against</u> Dr. Otoadese including any pending lawsuits, they do seek to discuss the lawsuit that Dr. Otoadese filed because it was filed in response to losing his privileges. It also establishes that notwithstanding any confidential settlement he has not performed

open heart surgeries which constitute 50 to 60% of the work time that he performed at that time. It is part and parcel of his qualifications and his practice. The jury is entitled to know all aspects of his qualifications, not just those that the defendant wishes to disclose. To only disclose what the defendant wishes to disclose would mislead this jury.

Part 2:

Pages 41-43: In these sections, Dr. Otoadese is describing a series of events related to post-stroke care of Mr. McGrew. He is also describing a conversation he had with Dr. Hassani about whether Mr. McGrew should be taken back to surgery. This is Dr. Otoadese describing the event and uses the conversations that he had with Dr. Hassani to explain the events. This is not hearsay. It is not being offered for the truth of the matter asserted. Rather, it is offered to describe the progression of events that took place. There is also no speculation as Dr. Otoadese has firsthand knowledge of the events.

Pages 44-45: The same analysis applies to this conversation. Again, it is not offered for the truth of the matter asserted but rather offered to explain the progression of events that took place and Dr. Otoadese's decision-making and conduct.

Part 3: Plaintiffs anticipate that Dr. Otoadese will testify that he obtained informed consent to the procedure. He has indicated that as part of that consent he

disclosed to Mr. McGrew and his daughter all the treatment options. These questions relate to that subject matter and are clearly related to the case. Further, one of the factual disputes is what information was provided by Mr. McGrew and documented in the medical chart. How Dr. Otoadese dictates and what parts are information that he obtained and what parts are information that some other person in his office obtain and documented is relevant to the jury's determination of what occurred on August 18, 2014. These questions elicit how the documentation was prepared.

Part 4: There will be conflicting testimony as to the significance of the carotid ultrasound done on August 6, 2014. One of defendants' experts contends that the carotid ultrasound was abnormal, while others contend that it was normal. For example, Dr. Mauer will testify that he ordered the carotid ultrasound and he relied upon it in determining what recommendations to make to Mr. McGrew. On the other hand, Dr. Otoadese testified that he put literally no weight on the ultrasound. He claims that the ultrasound cannot be relied upon because it was performed at an outside facility. Plaintiffs inquired whether he could have performed his own ultrasound at his own facility, and he responded as set forth in this section. This information is relevant and exclusion of it would be error.

Part 5: As noted in response to Defendants' motion in limine, plaintiffs claim that Dr. Otoadese did not obtain adequate informed consent. Defendants

have an idea of what they think is informed consent; plaintiffs have their own viewpoint. This includes not only what he told them but also what he didn't tell them. Iowa case law focuses on what a patient would want to know. While expert testimony is needed in order to understand the treatment options and risks and benefits of a procedure, it is not the only evidence available to establish such a claim. There will be significant disagreement between the parties as to whether surgery was necessary and to the extent that surgery would be appropriate whether the patient was properly advised about the risks of the surgery. One of the issues that a jury can consider is whether the risk of not doing surgery is as important as knowing the risk of doing surgery. In order to assess that claim, the jury needs to have this information. This is simply part of the information that he needs to know.

II. General Objections:

a. IRCP 1.704 permits a party to use a deposition of a party "for any purpose".

Defendants seek to prevent plaintiffs from reading or showing portions of the deposition of Dr. Otoadese while also calling him as a live witness. At this time, plaintiffs only intend to offer his deposition testimony, but do not want to be limited in also calling him as a witness. Defendants cite to no rule or other authority that would prohibit them from doing so. IRCP 1.704 states:

Any part of a deposition, so far as admissible under the rules of evidence, may be used upon the trial.... against any party who appeared when it was taken... to do any of the following:
(2) For any purpose if, when it was taken, deponent was a party adverse to the offeror...
IRCP 1.705(1) further provides "[I]f a party offers only part of a deposition, any other party may require an offer of all of the deposition relevant to the portion offered, the deposition...."

The rules recognize that a party may choose to show or read to the jury any part of a deposition of another party so long as the other party is given an opportunity to designate other parts relevant to the portion that is being offered. Such an offer was made in this case and defendants have so designated. The rules anticipate that a party may do so without having to read the entire deposition and may do so in a piecemeal fashion. In other words, that there may be more than one excerpt to be shown or read.

There is no rule that prohibits reading parts of an opposing party's previous testimony and also calling the individual as an adverse witness. Given the fact that a party opponent's deposition is essentially an admission, it is reasonable that one could read parts of the deposition to establish admissions and then call the individual as an adverse witness. In fact, you can do it in a serial fashion.

b. IRCP 1.704 and 1.705 permit a party to show or read excerpts from a party opponent's deposition throughout the trial.

As noted above, the rules anticipate that one would read excerpts from a party opponent's deposition throughout the trial. IRCP 1.705 allows a party to designate parts of a deposition so long as other parts relevant to the part to be read are also included. Defendants do not cite to any authority for the position that it is taking. There is nothing that prohibits a party from reading in different segments throughout the trial. IRCP 1.704 permits any part of a party opponent's deposition to be read "for any purpose." In this case, plaintiffs can read the deposition of Dr. Otoadese at different times of the trial because it will be "for any purpose" that it believes will aid in their presentation of their case.

c. Plaintiffs do not intend to show or read deposition excerpts during voir dire or opening statements.

However, plaintiffs are not precluded from otherwise using any admissions during opening statements.

Respectfully submitted,

<u>/s/ Martin A. Diaz</u> MARTIN A. DIAZ 000009676 ICIS AT0002000 1570 Shady Ct. NW Swisher, IA 52338 319-339-4350 telephone 319-339-4426 facsimile Attorney for Plaintiffs

copy: Per EDMS

IN THE IOWA DISTRICT COURT IN AND FOR BLACK HAWK COUNTY

19 MAR -7 PM 1:36

WILLIAM MCGREW and ELAINE,)
MCGREW)
Plaintiff,)
)
vs.)
)
EROMOSELE OTOADESE, M.D., and)
NORTHERN IOWA)
CARIOVASCULAR AND)
THORACIC SURGERY CLINIC P.C.)
Defendants)

.

Law No. LACV130355 CLERK OF DISTRICT COURT

JURY INSTRUCTIONS

Members of the Jury.

This trial arises out of medical treatment involving William McGrew as the patient and Dr. Otoadese as the physician. The McGrews allege that Dr. Otoadese was negligent in his care and treatment of William McGrew and as a result of this alleged negligence, William McGrew and Elaine McGrew were damaged.

Dr. Otoadese denies that he was negligent, denies causing damage to William McGrew and Elaine McGrew or denies the extent of the damages to William McGrew or Elaine McGrew, if any.

Do not consider this summary as proof of any claim. Decide the facts from the evidence and apply the law which I will now give you.

INSTRUCTION NO. 6

The fact that a party is a corporation should not affect your decision. All persons are equal before the law, and corporations, whether large or small, are entitled to the same fair and conscientious consideration by you as any other party.

Defendants, Dr. Eromosele Otoadese and Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. are to be treated as a single party for the purposes of these instructions. When I refer to Dr. Otoadese in these instructions, I am also referring to Defendant Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C.

INSTRUCTION NO. 9

William and Elaine McGrew claim that Dr. Otoadese was negligent. In order to prevail on this claim, William McGrew must prove all of the following propositions:

- 1. Dr. Otoadese was negligent by failing to meet the standard of care in performing an unnecessary surgery on William McGrew's right carotid artery on September 2, 2014
- 2. Dr. Otoadese's negligence, if any, was a cause of damage to William McGrew.
- 3. The amount of damage.

If William McGrew has proved each of these propositions, he is entitled to damages in some amount. If William McGrew has failed to prove any of these propositions, then you are to consider his claim for inadequate informed consent in Instruction No. 13.

***		7 PM 1:	
WILLIAM MCGR	EW and ELAINE OF I	NSTRICT	COURI 7. TOWA
	Plaintiff,		Law No. LACV130355
vs.))	ORDER OF JUDGMENT
NORTHERN IOW.	OADESE, M.D., and A CARDIOVASCUI SURGERY CLINIC Defendant.	AR))

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

This matter came before the Court for jury trial on February 26 through March 5, 2019. A jury verdict form appropriately signed by the presiding juror was duly received by the Court on March 5, 2019. A copy of the verdict form is attached to this Order.

Judgment is hereby accordingly entered in favor of the Defendants, Eromosele Otoadese, M.D., and Northern Iowa Cardiovascular and Thoracic Surgery Clinic PC. The costs of this matter are assessed to the Plaintiff. Counsel may file any additional necessary pleading as concerns the costs of this matter.

By prior order of the Court all exhibits entered in this matter shall have a security level of 2 as said exhibits may contain personal, confidential or unredacted information. An Exhibit Management Order will be entered as a separate document reflecting this security level.

Signed on 3/7/2019.

BY THE COURT:

KELLYANN M. LEKAR, JUDGE

Copies to: Counsel of record

IN THE IOWA DISTRICT COURT IN AND FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE)	
MCGREW,	Law No. LACV130355
Plaintiff,)	
)	
vs.)	VERDICT FORM
)	
EROMOSELE OTOADESE, M.D. and)	(*************************************
NORTHERN IOWA)	()
CARDIOVASCULAR AND)	
THORACIC SURGERY CLINIC P.C.)	C .
Defendant.	

We find the following verdict on the questions submitted to us:

Question No. 1: Was Dr. Otoadese negligent in his decision to perform surgery on

William McGrew on September 2, 2014?

Answer "yes" or "no."

ANSWER: No

[If your answer is "yes", then proceed to Question No. 2. If your answer is "no," then go

to Question No. 3.]

Question No. 2: Was the negligence of Dr. Otoadese a cause of damage to William

McGrew?

Answer "yes" or "no."

ANSWER:

[If your answer is "yes", then proceed to Question No. 5. If your answer is "no," then go to Question No. 3.]

Question No. 3: Was Dr. Otoadese negligent in obtaining informed consent from William McGrew?

Answer "yes" or "no."
<u>ANSWER</u>: <u>No</u>

[If your answer is "yes", then proceed to Question No. 4. If your answer is "no," then do not answer further questions.]

Question No. 4: Was the negligence of Dr. Otoadese a cause of damage to William McGrew?

Answer "yes" or "no." ANSWER:

[If your answer is "yes", then proceed to Question No. 5. If your answer is "no," then do not answer further questions.]

DAMAGES

Answer Question Nos. 5 and 6 only if you answered "yes" to Question Nos. 2 or 4.

<u>Question No. 5</u>: State the amount of damages sustained by William McGrew for each of the following items of damage. If William McGrew has failed to prove any item of damage, enter 0 for that item.

- - 5. Future Pain and Suffering

TOTAL (add the separate items of damage)

[Go to Question No. 6]

\$_____\$_____\$_____

Question No. 6: State the amount of damages sustained by Elaine McGrew for each of the following items of damage. If Elaine McGrew has failed to prove any item of damage, enter 0 for that item.

- 1. Past Loss of Consortium
- 2. Future Loss of Consortium

TOTAL (add the separate items of damage)

ð	 	
\$	 	_
\$		

Taylor Brown PRESIDINC

*To be signed only if verdict is unanimous.

Juror **

Juror**

Juror**

Juror**

Juror**

Juror**

Juror**

**To be signed by the jurors agreeing to it after six hours or more of deliberation.

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE	
MCGREW,	
Plaintiffs,)) NO. LACV130355
vs.	
) DEFENDANTS' RESISTANCE TO
EROMOSELE OTOADESE, M.D.; and) PLAINTIFFS' SUPPLEMENTAL
NORTHERN IOWA CARDIOVASCULAR) MOTION FOR NEW TRIAL
AND THORACIC SURGERY CLINIC,	
P.C.,) WITH AUTHORITIES
Defendants	

Defendants Dr. Eromosele Otoadese and Northern Iowa Cardiovascular and Thoracic Surgery Clinic, P.C. (collectively "Dr. Otoadese") resist Plaintiffs' Supplemental Motion for New Trial ("Supplemental Motion") and Plaintiffs' Supplement to their Supplemental Motion and state: ¹

1. Plaintiffs present the issue in their Supplemental Motion as one subject to the Court's discretion. *See* Supplemental Motion at 4.

2. It is well within the Court's discretion to find there was no "misconduct" or "irregularity" and that Plaintiffs were not prejudiced. *See* Rule 1.1004. Plaintiffs are not entitled to a new trial.

3. Dr. Otoadese does not agree or concede that Plaintiffs' Supplemental Motion for New Trial is timely. The judgment (with the verdict) was filed March 7, 2019 and Plaintiffs filed their Supplemental Motion on April 22, 2019 without a motion for leave to do so or a

¹ Defendants refer herein to documents attached to Plaintiffs' Supplemental Motion, including:

[•] Defendant's Answers to Plaintiff's Interrogatory No. 7, served Dec. 7, 2016 ("Interrogatory Answer")

[•] Iowa Board of Medicine Press Release and Statement of Charges and Settlement Agreement (Combined), approved by the Board April 12, 2019 ("Board's Order")

motion for extension of time. *See* Rule 1.1007 (motion for new trial must be filed within 15 days after filing the verdict unless an extension of no more than 30 days is granted). Without waiving this argument, Dr. Otoadese addresses the merits of Plaintiffs' Supplemental Motion below.

WHEREFORE for the reasons set forth above and below, Dr. Otoadese requests that Plaintiffs' Supplemental Motion for New Trial be denied.

ARGUMENT

I. The Iowa Board of Medicine information upon which Plaintiffs rely does not include or represent an admission of incompetence and only became available after trial.

There are two threshold issues which defeat Plaintiffs' Supplemental Motion: 1) the Iowa Board of Medicine ("Board") information does *not* represent an admission by Dr. Otoadese that he was negligent or incompetent, and 2) the information upon which Plaintiffs rely became available *after* trial was concluded in this matter.

A. There was no admission or finding of incompetence or negligence.

Plaintiffs' Supplemental Motion is based at least in part upon the assumption that Dr. Otoadese has admitted he was negligent or incompetent. *See* Supplemental Motion at 3 ("His [settlement] agreement constitutes an admission of professional incompetence."); Plaintiffs' Supplement to Supplemental Motion, filed April 29, 2019, at 1 (arguing Dr. Otoadese may have testified untruthfully given he "admitted to the Iowa Board of Medicine that he was professionally incompetent in treating [Mr. McGrew]"). Plaintiffs are mistaken.

The Board's Order is a Combined Statement of Charges and Settlement Agreement. It expressly states that it "constitutes the resolution of a contested case proceeding." Board's

Order at 5 ¶13. There was no finding by the Board of professional incompetence or admission by Dr. Otoadese.

An examining board's statement of charges is just that—charges. Charges prove nothing. In *McClure v. Walgreen Co.*, 613 N.W.2d 225 (Iowa 2000), the Iowa Supreme Court held that a statement of charges and settlement documents (in which a pharmacy agreed to be on probation) were inadmissible in a civil case involving the pharmacy. *Id.* at 235-37. The Court held:

The statement of charges was irrelevant because it was merely assertions of wrongdoing. None of the matters in the statement of charges was either proved or disproved.

Because the statement of charges and the stipulation and consent order were irrelevant and therefore inadmissible, we do not reach the balancing questions under rule 403.

Id. at 236-37 (but noting that "tone of the charges conveys an atmosphere of criminality").² In *McClure*, the statement of charges concerned the very same incident that was the subject of the litigation. *Id.* at 234. The Court still found the charges irrelevant. *See also id.* at 236 (finding board evidence "*proved nothing*") (emphasis added); *In re Ziegler*, 2006 WL 623685 *3 (Iowa Ct. App. 2006) ("a theft charge is not tantamount to a theft conviction. It is an accusation, not an act. While evidence of the latter is admissible to attack a party's credibility, evidence of the

former is not.")

Not only is a statement of charges irrelevant, as reflecting "mere[] assertions of wrongdoing," the settlement agreement also proves nothing and is not an admission. The *McClure* Court found that nothing in the settlement with the licensing board "amounted to an *admission* of wrongdoing." 613 N.W.2d at 236 (emphasis in original). Instead, the settlement

 $^{^{2}}$ The *McClure* Court reversed a judgment on punitive damages and remanded on that issue given the improperly admitted evidence. *Id.* at 237.

was "'motivated by a desire for peace *rather than from a concession of the merits*.'" *Id.* (emphasis added) (quoting Am. Jur. 2nd).

In this case, Dr. Otoadese and the Board resolved the dispute represented by the Board's charges. There was no hearing. There was no finding or admission of professional negligence or incompetence. There was a settlement. *See* Board Order at 1 (citing Iowa Code §272C.3(4) which provides licensing boards have authority to settle a matter with a licensee). Plaintiffs cannot unilaterally convert a settlement of disputed charges into an adverse finding or an admission of incompetence. Attempting to do so is also completely inconsistent with the public policy favoring settlement of controversies³ and Rule of Evidence 5.408.

In sum, the Iowa Supreme Court has decided how a district court is to view a licensing board's statement of charges and settlement agreement. Charges are "assertions of wrongdoing" which have not been proven and a settlement agreement is not a "concession of the merits" nor an admission. Plaintiffs' suggestion that they were denied an "admission of professional incompetence" and that Dr. Otoadese may have testified untruthfully because he had admitted incompetence lacks all merit. The charges and settlement agreement are irrelevant (even if they had pre-dated trial in this case) and there was no admission.

B. The Board Order was entered post-trial.

The second threshold problem is that the Board's Order was approved April 12, 2019 over five weeks after the verdict in this case on March 5, 2019. The Board made its Order public on April 19, 2019—over six weeks after the verdict. As explained further below, under Iowa law this public information is all that ever would have been available to Plaintiffs as all

³ "The law favors settlement of controversies and, accordingly, 'we have long held that voluntary settlements of legal disputes should be encouraged, with the terms of settlement not inordinately scrutinized." *Fees v Mutual Fire & Auto. Ins. Co.,* 490 N.W.2d 55, 58 (Iowa 1992) (citing *Wright v. Scott*, 410 N.W.2d 247, 249 (Iowa 1987).

other Board evidence is privileged.⁴ And, if it had been available before trial, it would have been inadmissible. But it was *not* available until *after* the trial was completed in this matter. It cannot support a new trial.

II. There was no "misconduct" during discovery.

The interrogatory is multi-part, asking initially about discipline, statements of charges, letters of warning, or investigations and then, in more detail, asking about licensure suspensions, revocations, terminations, or restrictions. Counsel objected to the interrogatory as seeking information protected by statutory peer review privileges (which was a proper objection as explained below) and then stated "without waiving and subject to these objections, Defendant states no." Counsel did not accurately read the entire list of subjects in the interrogatory and mistakenly answered "no." This was counsel's error, not Dr. Otoadese's. Given activity that could be interpreted as an "investigation," Counsel should have either only objected or alternatively could have stated "without waiving and subject to these objections, see any information that is publicly available or may become publicly available in the future." Given the misreading of the interrogatory, counsel did not supplement or amend the answer. The undersigned represents to the Court that the answer was in no way an intentional or deliberate attempt to mislead Plaintiffs or the Court. It was a mistake.⁵

Defendants respectfully submit the Interrogatory Answer does not represent "misconduct" to support a new trial. In a case cited by Plaintiffs, *Loehr v. Mettille*, 806 N.W.2d

⁴See Iowa Code §272C.6(4) ("all complaint files, investigation files, other investigation reports, and other investigative information in the possession of a licensing board . . . are privileged and confidential").

⁵ In the event Plaintiffs suggest that defense counsel intentionally set out to be misleading or inaccurate, Defendants respectfully remind the Court of the offer of proof of Dr. Halloran where it was made clear that his initial testimony elicited by Plaintiffs' counsel to support Plaintiffs' argument that Dr. Halloran was a treating physician was misleading, if not inaccurate. On cross, Dr. Halloran testified that he "absolutely" did not consider himself to be a treating physician before coming to the courthouse the day of his testimony. See Exh. 3 attached to Defendants' Resistance to Plaintiffs' Motion for New Trial at 12:11-13:10 (rough draft of Halloran offer of proof).

270 (Iowa 2011), the Iowa Supreme Court addressed allegations of counsel misconduct and whether the conduct caused prejudice. The Court found neither and reversed the district court's grant of a new trial. *See* 806 N.W.2d at 271.

In *Loehr*, the defense attorney presented an exhibit during trial which was discovered later to be something other than represented to the jury. 806 N.W.2d at 275-76. The plaintiff asserted there was misconduct, warranting a new trial. Instead of finding there was an intentional and deliberate wrongdoing to mislead the jury, the Supreme Court found there was an understandable error. 806 N.W.2d at 279-80 (describing issue as caused by "careless reading and wishful thinking"). The Court declined to disbelieve counsel's explanation of the error and found that it was "implausible" for counsel to have intentionally acted to mislead given that the error could be easily found out. *See id.* at 280 ("if one were going to fabricate an exhibit ... it seems implausible [to leave information that would disclose the issue]"). The Court found an "absence of real misconduct." *Id.* at 271.

Similarly, in this case, to find "misconduct" the Court would have to disbelieve the undersigned's explanation and find defense counsel intentionally set out to provide inaccurate discovery responses.⁶

The undersigned respectfully submits that there was a mistake—not misconduct.

III. Plaintiffs cannot show prejudice—Board investigative information is not discoverable and not admissible.

Even when there is a finding of misconduct to support a motion for new trial, the Court must still find it caused prejudice in order to grant a new trial. *See Loehr*, 806 N.W.2d at 280 ("Even if there had been misconduct, we cannot agree it prejudiced the Loehrs."); *Mays v. C. Mac Chambers Co.*, 490 N.W.2d 800, 803 (Iowa 1992) (" 'unless it appears probable a different

⁶ Determining whether there was "misconduct" is a matter within the Court's discretion. *Loehr*, 806 N.W.2d at 277.

result would have been reached but for claimed misconduct of counsel for the prevailing party,' we are not warranted in granting a new trial").

In order to show prejudice, Plaintiffs must establish they would have been allowed to discover and introduce evidence about the Board investigation. These issues—matters of discovery, the admissibility of evidence, and the presence of prejudice--are matters of discretion. *See Carolan v. Hill*, 553 N.W.2d 882, 886 (Iowa 1996) ("The district court is vested with wide discretion in rulings on discovery matters."); *Graber v. City of Ankeny*, 616 N.W.2d 633, 638 (Iowa 2000) (admissibility of evidence is reviewed for an abuse of discretion); *Mays*, 490 N.W.2d at 803 ("Furthermore, we have held that the trial court 'has considerable discretion in determining whether alleged misconduct, if there was such, was prejudicial."")

Another threshold applicable legal principle concerns the impact of a privilege on the scope of discovery and the admissibility of evidence. *See Carolan v. Hill*, 553 N.W.2d 882, 886-87 (Iowa 1996) (rejecting narrow reading of peer review privilege); *Chung v. Legacy Corp.*, 548 N.W.2d 147, 151(Iowa 1996)(applying physician-patient privilege at Iowa Code §622.10 to protect information, "We recognize our holding will preclude discovery and admission of relevant evidence. That fact, however, is no reason not to apply the privilege . . ."); *Id.* (quoting *Muller v. Rogers*, 534 N.W.2d 724, 726 (Minn. App. 1995), "the rules of privilege codify policy determinations that certain relationships and situations are deserving of protection, even if crucial information is thereby withheld."").

A. Board investigative information is privileged, not discoverable, and not admissible—Plaintiffs would not have been entitled to discovery on this subject.

Plaintiffs acknowledge that Board of Medicine activities are confidential. *See* Supplemental Motion at 3-4 (citing Iowa Code §272C.6(4)); *id.* note 2 (stating "The only

information belonging to the Board of Medicine that is not confidential would be the statement of charges and settlement agreement."). Plaintiffs are correct. Iowa law provides strong confidentiality protection to all Board of Medicine activity leading up to any publicly filed material. *See* Iowa Code §272C.6(4) ("all complaint files, investigation files, other investigation reports, and other investigative information in the possession of a licensing board ... which relates to licensee discipline are privileged and confidential, and are not subject to discovery, subpoena, or other means of legal compulsion for their release to a person other than the licensee and the boards, ... and are not admissible in evidence"); *see also* 653 IAC 24.2(8) (re confidentiality of investigative information).

And the Board strictly adheres to the privileged nature of investigations. The Board's web site includes a consumer brochure, stating:

The Iowa Board of Medicine is required by state law to maintain the confidentiality of all information related to Board investigations. This includes complaints and investigative reports. Consequently, complainants cannot receive information or be briefed on any aspect of the investigation or how the case is resolved beyond what is presented in public documents about the case.

Feb. 20, 2015 Press Release with Consumer Guide attached.⁷

In light of the impenetrable privilege afforded Board activity other than publicly filed information, Plaintiffs argue that the privilege "does not extend to the licensee (Dr. Otoadese)." Supplemental Motion at 4. Plaintiffs then suggest Dr. Otoadese could have been forced to disclose details about the Board's investigation such as allegations, investigation status, and investigation witnesses. *Id.* In other words, Plaintiffs argue that a patient in a medical malpractice action could obtain Board investigative information pertaining to a defendant physician by simply propounding discovery to the physician, notwithstanding that the

⁷ Available at <u>https://medicalboard.iowa.gov/z-index-0</u> (last accessed May 4, 2019).

information is not discoverable from the Board. This, of course, completely eviscerates the statutory privilege and there are many reasons why Plaintiffs would not have been permitted to obtain information from Dr. Otoadese that they could not obtain from the Board.

Plaintiffs cite no case in which a court allowed a party to skirt a statutory peer review privilege by seeking privileged material from the professional who was subject to the peer review.⁸ However, in *Hall v. Broadlawns Med. Ctr.*, 811 N.W.2d 478 (Iowa 2012), the Court acknowledged the problems with the "possession" language in Iowa Code §272C.6(4) which protects "information in the possession of a licensing board." The Court observed: "*At first blush*, it may appear that the statute only protects information 'in the possession of a licensing board or peer review committee." *Id.* at 482-83 (emphasis added). The Court continued that "the interpretation of the statute based on possession is problematic" and it approved an argument that protection "runs with the information" as opposed to the possessor. *Id.* at 483. The *Broadlawns* Court discussed the compelling position that it would defeat the public policy behind peer review protections if information protected in the hands of a peer review committee could, as a matter of course, be obtained from others—such as the subject physician. *Id.* at 483-84; *see also id.* at 484 ("the mere fact that a copy of [peer review] is

⁸ Other courts have addressed whether peer review information in the hands of physicians was discoverable. *See Hillsborough County Hosp. v. Lopez*, 678 So.2d 408 (Fla. Ct. App. 1996) (finding hospital's disclosure of peer review information to treating physicians did not defeat the privilege and render information admissible); *Nga Le v. Stea*, 286 A.D. 2d 939 (S.C. App. Div. N.Y. 2001)(finding no waiver of peer review privilege because there "was no intentional relinquishment of the privilege" when hospital shared report with one of the physicians involved in the plaintiff's care and subject to the peer review); *Young v. Saldanha*, 431 S.E.2d 669, 671, 674, fn.2 (W.Va.1993)(fact that physician reviewed own peer review (as allowed under the statute) did not defeat privilege in medical malpractice case); *Columbia Park Med. Center v. Gibbs*, 723 So.2d 294, 295 (Fla. Ct. App. 1999)(hospital's disclosure of privileged documents concerning physician privileges to physicians who were not on peer review committee did not defeat privilege).

possessed by a third party should not be determinative of the privilege issue if the privilege is to have any substance"). ⁹

Under the *Broadlawns* reasoning, Board investigative information is no more discoverable from Dr. Otoadese than it is from the Board. *See also Cawthorne v. Catholic Health Initiatives*, 743 N.W.2d 525, 528 (Iowa 2007) (§272C.6(4) "should protect the source of information *as well as the person being investigated*") (emphasis added).

Further, to allow a plaintiff in a medical malpractice case to discover Board investigative information from the physician would defeat the purpose for statutory peer review privileges. The purpose of the Board privilege is described in the statute: "In order to assure a free flow of information." *See* §272C.6(4)(a). If Board investigative information is allowed to be discovered from the physician for use in civil litigation, it would chill the free flow of information. In finding a broad peer review privilege in Iowa Code §147.135(2), the Iowa Supreme Court has emphasized the chilling effect on the desired goal of medical evaluation if peer review documents are used in civil litigation. "Peer review privileges encourage an effective review of medical care. . . . Without broad protections, physicians would be very reluctant to participate, knowing the information could easily be revealed in a court of law." *Carolan*, 553 N.W. 2d at 886-87; *see also. Bredice v. Doctor's Hospital*, 50 F.R.D. 249, 250 (D.D.C. 1970).

As Justice Appel discussed in *Broadlawns*, the privilege can be viewed as running with the "information" not the possessor. Some courts view it as protecting the process. It would defeat peer review privileges to allow a plaintiff to circumvent the privilege meant to foster the "free flow of information" and obtain privileged information from the subject of the process—the affected licensee. *See, e.g., Marshall v. Planz*, 145 F. Supp.2d 1258, 1273-74 (M.D. Ala.

⁹ The *Broadlawns* Court found the records at issue were not privileged but the records were in the hands of a third party and were created for a purpose independent of the licensing board's investigation. *See* 811 N.W.2d at 844-45.

2001) ("The peer review privilege exists to protect the interests of not just one person but rather the entire peer review process (which exists not just for physicians but rather to improve the quality of medical care for all) and *all* those involved, including peer review committees, physicians who participate in them, and others who fall under its protection; it is personal not to one particular person but rather to the entire process and all those involved as a group") (emphasis in original).

Adding to the list of reasons why Plaintiffs would not have been allowed the discovery they suggest is the fact it would involve the confidential and privileged medical information of non-parties. The Board evidence pertains to five patients. *See* Board Order. Thus, it necessarily implicates the privacy interests of non-parties. Those non-party patients did not consent to their medical information being made part of this case. Their identity and medical information is safely protected in the hands of the Board. However, under Plaintiffs' suggestion Board investigative information (which would include the identity and medical information of non-parties) was discoverable from Dr. Otoadese. The physician-patient privilege separately protects such non-party information and would defeat an attempt by Plaintiffs to discovery Board information from Dr. Otoadese.¹⁰ In addition, Dr. Otoadese would be unable to fully respond to the Board evidence given the confidential and separately privileged medical information involving nonparty patients.

For the reasons set forth above, Plaintiffs would not have been allowed discovery on Board of Medicine activity regardless of the answer to the interrogatory. In addition, the evidence would also not have been admissible at trial as discussed below. Thus, any discovery

¹⁰ See, e.g., Iowa Code §622.10; *Head v. Colloton*, 331 N.W.2d 870, 876 (Iowa 1983)(recognizing patient's right to privacy in the context of medical information *and* their identity, based upon the constitution, common law, and the fiduciary duty owed by the provider; and physician and hospital's duty to safeguard privacy); 45 CFR 164. 502 (Health Insurance Portability Act (HIPAA) prohibition against disclosure of protected information).

would not be reasonably calculated to lead to the discovery of admissible evidence. *See* Rule 1.503(1).

B. Even if disclosed to Plaintiffs in discovery, any Board investigation information and any pending charges and settlement agreement would have been inadmissible at trial.

The Board Order was dated *after* trial (April 12, 2019). Thus, any activity leading up to that April 12, 2019 Order would have been in the nature of Board investigative information and such information is not admissible. *See* Iowa Code §272C.6(4).

Assuming without conceding that Plaintiffs would have been entitled to learn in discovery that there was activity in the Board of Medicine prior to trial, that in no way supports the jury would have heard this information. The Iowa Supreme Court has held: "We hold that [§]272C.6(4) prohibits admission of [Board] investigative evidence and that introduction of the IBME investigation . . . was improper." *Cawthorne v. Catholic Health Initiatives*, 743 N.W.2d 525, 528 (Iowa 2007) (remanding case for new trial given trial court erroneous admission of Board investigative information; noting §272C.6(4) contains an "express prohibition from admission.").¹¹ The second time the Supreme Court ruled on *Cawthorne*, it clarified that a disclosure of statutorily privileged peer review in discovery did nothing to impact the inadmissibility of the privileged information. *See Cawthorne v. Catholic Health Initiatives*, 806 N.W.2d 282, 289-90 (Iowa 2011) (addressing Iowa Code §147.135(2),¹² finding the separate bar against admissibility cannot be waived).

¹¹ In *Cawthorne,* the physician had *waived* his right to confidentiality, yet the Iowa Supreme Court found such a waiver did not defeat the statute's prohibition against admission. *See* 743 N.W.2d at 527-28.

¹² Like Iowa Code §272C.6(4), Iowa Code §147.135(2) provides that peer review records "are privileged and confidential, are not subject to discovery, subpoena, or other means of legal compulsion for release to a person other than an affected licensee or a peer review committee and are not admissible in evidence" *See* Iowa Code §147.135(2) (protecting "all complaint files, investigative files, reports, and other investigative information relating to licensee discipline or professional competence in the possession of a peer review committee or an employee of a peer review committee.").

Further, Board evidence would have also been inadmissible under Rules 5.402, 5.403, 5.404(b), and 5.408. Even if Plaintiffs had learned of the presence of an investigation and the possibility of future public information from the Board—it would not have been admissible.

Plaintiffs tried unsuccessfully to admit similarly unfairly prejudicial evidence against Dr. Otoadese including the circumstances under which Dr. Otoadese left a prior professional clinic (Cedar Valley Specialists) which involved a lawsuit and settlement and circumstances under which Dr. Otoadese stopped doing open heart surgery at Allen Hospital which involved a lawsuit, settlement, and privileging issues. The Court correctly excluded the evidence. Any Board-related evidence would have been treated no differently.

Rule 5. 402. As discussed above the Board "charges" proved nothing and are merely unproven assertions of wrongdoing and the settlement agreement cannot be interpreted as an admission or concession of wrongdoing. The Board evidence is irrelevant. *See McClure*, 613 N.W.2d at 236-37.

Rule 5. 403. While the *McClure* Court did not exclude board evidence under Rule 5.403 because it found the evidence was not relevant, it clearly acknowledged its prejudicial character. *See McClure*, 613 N.W.2d at 237 (noting the inherently prejudicial nature of evidence of licensing board charges as the "tone of the charges conveys an atmosphere of criminality"); *see also Cawthorne*, 743 N.W.2d at 528 (finding the impact of improper admission of Board investigative information was "so great" as to require a new trial); *Bray v. Hill*, 517 N.W.2d 223, 225-226 (Iowa Ct. App. 1994) (affirming trial court's exclusion of physician's probationary status as more prejudicial than probative under Rule 5. 403).

In *King v. Ahrens*, 16 F.3d 265 (8th Cir. 1994), a medical malpractice plaintiff attempted to introduce evidence that the defendant's medical license had actually been suspended (not the

case here) eight years earlier. *Id.* at 268. The plaintiff in *King* sought to introduce the evidence for impeachment. In affirming the trial court's exclusion of the evidence under Federal Rule 403, the Eighth Circuit found the "danger of unfair prejudice is substantial and immediately apparent" as the "license suspension by its very nature reflects badly" on the physician. *Id.* at 269. In *King*, there was a "great danger" the jury would use the evidence of administrative action¹³ to improperly infer that the defendant's conduct in that case was improper. *See id.* at 270.¹⁴

Further, the Board Order indicates it concerns five patients from 2009-2014. Thus, the

evidence would necessarily concern patient incidents that are unrelated to, and disconnected

from, the facts giving rise to this case. Evidence of other patient incidents and suits, is not

relevant, is highly prejudicial, and should not be admitted. See, e.g., Lai v. Sagle, 818 A.2d 237,

247-48 (Ct. App. Md. 2003).

The fact of prior litigation has little, if any, relevance to whether [the physician] violated the applicable standard of care in the immediate case. The admission of evidence of prior suits, instead of aiding the fact finder in its quest, tends to excite its prejudice and mislead it. . . .[We] cannot conceive of a more damaging event, in a medical malpractice trial, than disclosure to the jury in opening argument that the defendant doctor had previously been sued multiple times for malpractice.

¹³ Few subjects are more prejudicial than evidence of governmental penalties or sanctions. *See Gehl by Reed v. Soo Line R. Co.*, 967 F.2d 1204, 1208 (8th Cir. 1992) (affirming exclusion of a government safety assessment, "There is a danger that government reports, even if not particularly probative, will nonetheless sway the jury by their 'aura of special reliability and trustworthiness.'''); *Firemen's Fund Ins. Co. v. Thein*, 63 F.3d 754, 758-59(8th Cir. 1995) (Federal Aviation Administration reports and investigation would be highly prejudicial as "very likely would cause a jury to feel hostility toward [the defendant]'').

¹⁴ See also State of Iowa v. Henderson, 696 N.W.2d 5, 10-11 (Iowa 2005) (evidence is unfairly prejudicial when it "appeals to the jury's sympathies, arouses its sense of horror, provokes its instinct to punish, or triggers other mainsprings of human action that may cause a jury to base its decision on something other than the established propositions in the case"); *State of Iowa v. Langley*, 2005 WL 1965866 at * 5 (Iowa Ct. App. 2005) (evidence is unfairly prejudicial if it "would cause the jury to base its decision on something other than the proven facts and applicable law, such as sympathy for one party or a desire to punish a party"); *Estate of Long v. Broadlawns Medical Center*, 656 N.W.2d 71, 91 (Iowa 2002) (affirming exclusion of information as unfairly prejudicial under Rule 5.403 even though it "may have been relevant" to the issue of future damages).

818 A.2d at 247. This argument applies equally to prior licensing actions arising from other patients.

Evidence regarding the Board activity involving other patients would have led to the trial of collateral issues. Dr. Otoadese could have been forced to simultaneously defend -- or at the minimum explain -- the Board charges involving five patients.¹⁵

Even if there had been an actual adverse finding by the Board (which there was not), it would have been inadmissible as unfairly prejudicial. In *State v Huston*, 825 N.W.2d 531 (Iowa 2013), the Court reversed a conviction for child endangerment because a DHS caseworker was allowed to testify that a child abuse report had been determined as "founded." Even though the child abuse report arose out of the very same underlying facts as the proceeding at issue in *Huston*, the Court found the evidence irrelevant and unfairly prejudicial. *Id.* at 537-38. As the Court held:

Telling the jury [about the DHS administrative finding] was unfairly prejudicial due to the risk the jury would substitute [that] determination for its own finding of guilt or would give the determination undue weight.

Id. at 539.¹⁶ Similarly, allowing Plaintiffs in this case to present evidence about any Board activity—even the fact of the charges—would create the very real possibility that the jury would substitute the professional charges for its determination of a breach of the standard or would

¹⁵ See Top of Iowa Cooperative v. Schewe, 135 F.Supp. 2d 969, 975 (N.D. Iowa 2001)(excluding evidence of other lawsuits involving similar grain contracts, finding that each case is dependent upon its own circumstances and that evidence of other claims "presents the serious potential for confusion and for decisions on an improper basis."); *Firemen's Fund v. Thien*, 63 F.3d 754, 758-59 (8th Cir. 1995)(citation omitted) (evidence would require "extended, and irrelevant, litigation [on the collateral issue], and thus would confuse the jury and waste their time and the court's."); *Coast–to-Coast Stores, Inc. v. Womack-Bowers, Inc.*, 818 F.2d 1398, 1404 (8th Cir. 1987)(agreeing that if "other acts" were admitted, the defendant would have the right "to introduce rebuttal evidence . . . confusing the issues and wasting the time of the court and jury."); *Easley v. American Greetings Corp.*, 158 F.3d 974, 977 (8th Cir. 1998) (affirming exclusion of evidence that "would have opened the door to the introduction of evidence on collateral issues").

¹⁶ The Court cited multiple civil cases *and* specifically held that the evidence would not have been admissible even with a limiting or cautionary instruction about the lower burden of proof applicable in the DHS proceeding. *Id.* at 538-39.

give the evidence undue weight. The *Huston* Court recognized the danger when evidence from a "purportedly unbiased state agency" is introduced. *Id.* at 537-38. The appearance of official approval is unfairly prejudicial. *Id.*

Rule 5. 404(b). Board evidence would also be inadmissible under Iowa Rule of Evidence 5.404(b), under which a party cannot introduce character evidence or evidence of "other wrongs or acts" to prove that a person acted in conformity therewith.

The Iowa Supreme Court's discussion of the great danger when "other acts" are admitted into evidence in *State v. Henderson*, 696 N.W.2d 5 (Iowa 2005) is instructive. The Court reversed a conviction based on the prejudice caused by the admission of prior acts. While the majority affirmed that a prior marijuana conviction was relevant, the Court still held the district court abused its discretion in admitting the evidence as it was too prejudicial. *Id.* at 11-12.

The following factors apply to the analysis of the admission of other act evidence:

- "(1) the actual need for the evidence in view of the issues and other available evidence,
- (2) whether there is clear proof showing the other [acts] were committed by the accused,
- (3) the strength or weakness of the prior-acts evidence in supporting the issue sought to be proven, and
- (4) the degree to which the jury will probably be improperly influenced by the evidence."

696 N.W.2d at 11. The *Henderson* Court found the second and third factors supported admission in that case and still found the evidence should not have been introduced. *Id*.

Factor 1: In this medical malpractice case, there would be no need for evidence of

pending "charges," a pending "settlement," or information about the care and treatment of five

patients (when this case involved one patient). As set forth above, such Board evidence is not

relevant—charges prove nothing and settlements with licensing boards are not admissions. Nor

did this case involve the care of any patient other than Mr. McGrew.

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Factors 2 and 3: Here, the "other acts" were not proven at all—much less clearly proven. They were merely assertions of wrongdoing. And in order to determine the strength or weakness of the other acts, there would have to be a trial within a trial—or five trials within this trial—as to each of the five patient situations.

Factor 4: As in *Henderson*, the "degree to which the jury will probably be improperly influenced" would compel exclusion of any Board evidence:

When prior acts evidence is introduced, regardless of the stated purpose, the likelihood is very great that the jurors will use the evidence precisely for the purpose it may not be considered: to suggest that the defendant is a bad person... and that if he did it before he probably did it again.

696 N.W.2d at 12 (citation and internal quotations omitted); *id* at 13 ("It would be extremely difficult for jurors to put out of their minds knowledge [of the prior acts] and not allow this information to consciously or subconsciously influence their decision."); *see also id.* at 14 (J. Lavorato, concurring)("a defendant must be tried for what he did, not for who he is.")(citations and internal quotations omitted).

Rule 5. 408. The Board activity involves settlement—inadmissible under rule 5.408. See also McClure, 613 N.W.2d at 236.

IV. Conclusion.

The April 12, 2019 Board of Medicine Statement of Charges and Settlement Agreement was entered by the Board nearly five weeks after the verdict in this case. The charges constitute unproven assertions and the settlement resolved contested issues. There was no finding or admission of professional incompetence. While defense counsel mistakenly responded to discovery on this subject, it caused no prejudice to Plaintiffs. Any evidence other than that made public by the Board (here, after the trial of the case) is privileged, not discoverable, and not

admissible. Licensing board evidence -including investigations, charges, and settlements-

have been held by the Iowa Supreme Court to be inadmissible.

For the reasons set forth above, Defendants respectfully request that the Court deny

Plaintiffs' Supplemental Motion for a new trial in its entirety.

CERTIFICATE OF SERVICE
The undersigned hereby certifies that a copy of
this document was served upon counsel of record
for each party to the action in compliance with lowa
R.C.P. 1.442(b) on: 1
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Signature July U.M. uller
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cc: Martin A. Diaz, Esq. 1570 Shady Ct NW Swisher, IA 52338

> Mark L. Chipokas, Esq. Mark L. Chipokas, P.C. 866 First Avenue N.E. P.O. Box 1261 Cedar Rapids, IA 52406-1261

Honorable Judge Kellyann Lekar Kellyann.Lekar@iowacourts.gov

AT0006606 JENNIFER E. RINDEN VINCENT S. GEIS AT0013055 for SHUTTLEWORTH & INGERSOLL, P.C. 500 U.S. Bank Bldg., P.O. Box 2107 Cedar Rapids, IA 52406 PHONE: (319) 365-9461 FAX: (319) 365-8443 e-mail: jer@shuttleworthlaw.com ATTORNEYS FOR EROMOSELE OTOADESE, M.D.; NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.

WILLIAM MCGREW AND ELAINE MCGREW,	LACV130355
Plaintiffs,	
v.	ORDER
EROMOSELE OTOADESE, M.D.; AND NORTHERN IOWA CARDIOVASCULAR AND THORACIC SURGERY CLINIC, P.C.,	
Defendants.	

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

This matter came before the Court for purposes of hearing on post-trial motions on April 17, 2019, and again on July 29, 2019. For purposes of hearing on post-trial motions, the Plaintiffs appeared through counsel, Martin Diaz. The Defendants appeared through counsel, Jennifer Rinden.

An Order for Judgment in favor of the Defendant was entered on March 7, 2019, following a jury trial. A Motion for New Trial was filed on March 7, 2019. That Motion was resisted by Resistance filed March 20, 2019. A Reply to that Resistance was filed on March 21, 2019. The Court then proceeded with a hearing on post-trial motions on April 17, 2019. However, before the Court could rule on the post-trial motions, Plaintiffs filed a Supplemental Motion for New Trial on April 22, 2019, raising additional issues. That Motion was supplemented by Plaintiffs on April 29, 2019. That Motion was resisted on May 6, 2019. On May 7, 2019, the Plaintiffs filed a Motion for Leave to File Supplemental Motion for New Trial and a Reply to the Resistance to the Supplemental Motion for New Trial. A Resistance to the Plaintiffs' Motion for Leave to File Supplemental Motion for New Trial was filed on May 7, 2019. All pending Motions came before the Court for hearing on July 29, 2019.

Plaintiffs' Motion for New Trial filed March 7, 2019, alleged three primary grounds for a new trial: 1. the trial court should have permitted the testimony of Dr. John Halloran; 2. the trial court should have permitted the complete testimony of Dr. Ivo Bekavac; and 3. the trial court should have permitted the Plaintiffs to question the Defendant, Dr. Otoadese, concerning his loss of privileges to perform certain surgery and his termination from Cedar Valley Medical Specialists in 2012.

With regard to this Motion for New Trial, *Iowa Rule of Civil Procedure* 1.1004 requires that the Plaintiffs must establish that the court abused its discretion and that the substantial rights of the moving party were materially affected as a result. Abuse of discretion is the standard used in considering a court's ruling on the admission of a treating physician's testimony. *Hansen vs. Central Iowa Hospital Corp.*, 686 N.W.2d 476 (Iowa 2004). A court is deemed to have abused its discretion only if its decision was based on a ground or reason that is clearly untenable or when the court's discretion was exercised to a clearly unreasonable degree. *Cite Pexa vs. Auto Owners*, 686 N.W.2d 150 (Iowa 2004).

In support of their Motion for New Trial on the basis of the exclusion of the testimony of Drs. Bekavac and Halloran, the Plaintiffs argue that these physicians were disclosed in compliance with *Code of Iowa* Section 66A.11 and that the proposed opinions of these experts were fully disclosed through the medical records of these physicians that were produced through discovery and through Answers to Interrogatories relating to treating physicians. The Plaintiffs, therefore, argue that the treating physicians were fully disclosed and their expected opinions fully provided through full compliance with *Code of Iowa* Section 66A.11 and *Iowa Rule of Civil Procedure* 1.508. The Defendants argue that the designation of these two physicians as experts was provided through the identification of these physicians as "treating physicians" rather than experts retained for purposes of trial and that the Plaintiffs never provided signed expert reports for either physician. For these reasons, the Defendants argue that the testimony of these two physicians should be

limited to only knowledge and opinions held by these physicians as a result of the treatment and care of the Plaintiff and not with regard to standard of care or causation for purposes of this malpractice proceeding.

Each party extensively cites Hansen vs. Central Iowa Hospital Corp. as supportive of the position they took both at trial as well as in the course of post-trial motions. During the course of trial, the Court allowed an offer of proof with regard to each of the two treating physicians at issue, conducted extensive hearings with the parties concerning the potential admissibility of the opinions sought by the Plaintiffs, and also issued a formal ruling on the record concerning the admissibility of the expected testimony of these witnesses. This ruling included the Court's analysis and application of the *Hansen* decision to the issue during the course of trial. This Court relies on and incorporates the ruling made by the Court during the course of trial concerning the issue of the testimonies of Dr. Bekavac and Dr. Halloran. This Court continues to believe that the evidentiary determination made during the course of trial is correct under *Hansen* and is also correct under the *Iowa* Rules of Civil Procedure and the Code of Iowa. This Court is not persuaded on the Motion for New Trial that the Court's determination concerning the testimonies of Drs. Bekavac and Halloran was an abuse of discretion. Further, this Court incorporates the arguments made by the Defendants in Resistance to Motion for New Trial concerning the fact that even if the Court abused its discretion, the substantial rights of the Plaintiffs were not martially affected as a result of the ruling in light of the testimony that was permitted through Dr. Bekavac and the accompanying exhibits, as well as the testimony of the Plaintiffs' retained expert.

As concerns the Plaintiffs' other allegation of error concerning the admissibility of testimony and evidence surrounding Dr. Otoadese's loss of privileges and termination of his relationship with Cedar Valley Medical Specialists, the Court relies upon the rulings and analyses made on the record during the course of trial and declines to find that either an abuse of discretion occurred or that the Plaintiffs

were materially affected as a result of the rulings. The various evidence offered by the Plaintiffs concerning the ending of the relationship between Dr. Otoadese and Cedar Valley Medical Specialists, as well as Dr. Otoadese's privileges was not relevant to the issues to be decided by the jury in the present case and, further, even if relevant, had prejudicial effect that far exceeded any probative value that that evidence might provide. For the reasons stated above, the Plaintiffs' original Motion for New Trial will be denied.

As indicated, while this Court had the Motion for New Trial originally under advisement, the Plaintiffs filed a Supplemental Motion for New Trial on April 22, 2019. The Motion is brought pursuant to *Iowa Rule of Civil Procedure* 1.1004 concerning new trials. The basis of the Supplemental Motion for New Trial concerned a press release issued by the Iowa Board of Medicine on April 19, 2019, indicating that Defendant, Dr. Otoadese, had reached an agreement with the Iowa Board of Medicine relating to five complaints of professional incompetence occurring between 2009 and 2014. The specifics concerning the complaints are not revealed in the Board of Medicine documents nor are specific patients identified and, therefore, it is impossible for the Plaintiffs or for this Court to know if the Board action involves the Plaintiffs herein.

The Plaintiffs argue that based upon the knowledge gained from the press release by the Iowa Board of Medicine, that the Defendants engaged in irregularity in the proceeding before the Court or misconduct of the prevailing party by failing to disclose, supplement, or correct his Answer to Interrogatory No. 7 which had asked him to disclose whether he had ever been disciplined, had received a statement of charges or letter of warning, or had been investigated by a licensing board. The Plaintiffs go on to argue that the Plaintiffs were prejudiced by the Defendants' failure to disclose or supplement the Interrogatory answer.

In the Supplemental Motion for New Trial, the Plaintiffs further argue that the Combined Statement of Charges and Settlement Agreement represent an admission

by Dr. Otoadese that he was negligent or incompetent. The Defendants resist this argument on the basis that the Iowa Board of Medicine's Combined Statement of Charges and Settlement Agreement expressly states that it "constitutes the resolution of a contested case proceeding" without any specific admission of professional incompetence by Dr. Otoadese.

The Plaintiffs maintain that the Statement of Charges and Settlement Agreement does indeed represent a concession of professional incompetence. Specifically, the Plaintiffs point to Paragraph 6 of the Statement of Charges and Settlement Agreement wherein Dr. Otoadese agrees to be cited for professional incompetency regarding all five patients that are the subject of the Statement of Charges. The Plaintiffs point out that based upon the fact that the Iowa Board of Medicine does not identify the patients who are at issue in the Statement of Charges and Settlement Agreement, it is impossible for the Plaintiffs to know whether or not Paragraph 6 concerning professional incompetence relates specifically to the Plaintiffs in this matter as there is no way for the Plaintiffs to know, without information provided by either the Defendants or the Iowa Board of Medicine, the identity of the patients included in the Statement of Charges and Settlement Agreement. The Plaintiffs point out that this issue becomes critical when viewed in light of the fact that Dr. Otoadese testified at the trial of this matter with regard to the standard of care and whether or not he believed he had breached that standard of care with regard to the Plaintiff. If the Board inquiry and findings include the Plaintiff as a patient, an admission of professional incompetence in the Statement of Charges and Settlement Agreement would be in direct contradiction to the Defendant's testimony at the trial of this matter.

The Defendants cite the Supreme Court's holding in *McClure vs. Walgreen Co.,* 613 N.W.2d 225 (Iowa 2000) as supportive of its argument that a statement of charges and settlement documents should be inadmissible in a civil case involving, as a defendant, the subject of the examining board's statement of charges. The

Defendants further argue that the Iowa Board of Medicine's Combined Statement of Charges and Settlement Agreement was not issued until after the trial in this matter. The Defendants argue that said evidence was not available at the time of trial and, therefore, cannot support a motion for new trial. Further, the Defendants argue, even if the information which made its way into the Combined Statement of Charges and Settlement Agreement was available to the Defendants prior to the date of trial and had been provided to the Plaintiffs, said information would have been inadmissible under the holding of the *McClure* case and, therefore, no prejudice resulted to the Plaintiffs.

In addition, counsel for the Defendants state that any error made in not responding to the inquiry of Interrogatory No. 7 into "investigations" lies with counsel for the Defendants on the basis that counsel did not accurately read the entire Interrogatory and mistakenly answered in the negative. However, counsel points out that even if counsel had appropriately considered the use of the word "investigations" in the Interrogatory as giving rise to a response concerning the investigations which ultimately lead to the Combined Statement of Charges and Settlement Agreement, counsel's only obligation in responding to the Interrogatory would have been to refer the Plaintiffs to any information that is publicly available or may become publicly available concerning any investigations. The Defendants note that with regard to board reviews such as that involved here, Iowa law establishes that the only information that is made public is the fact that charges had been investigated and a settlement had been reached without publicly disseminating any information concerning the investigations.

The Plaintiffs argue that although information held by the Board of Medicine is confidential and not for public dissemination, such confidentiality does not extend to or prevent questioning of Dr. Otoadese on the topic. In response, the Defendants cite *Hall vs. Broadlawns Medical Center*, 811 N.W.2d 478 (Iowa 2012), as support for the argument that public policy would be defeated if information

protected in the hands of a board or peer review committee could be subject to discovery from a third party or the individual being reviewed. The Defendants argue that *Hall* stands for the proposition that the privilege can be viewed as running with the information and not the possessor of the information and that the process itself should be protected.

Finally, Defendants argue that Plaintiffs' Supplemental Motion for New Trial was untimely under *Iowa Rule of Civil Procedure* 1.1007, having been filed on April 22, 2019.

In response to the timeliness issue, the Plaintiffs point out that the press release concerning the Statement of Charges and Settlement Agreement was not made by the Iowa Board of Medicine until April 19, 2019, and that the Plaintiffs filed the Supplemental Motion for New Trial on April 22, 2019, immediately upon learning of the press release. The Plaintiffs argue that this information, which draws into question both misconduct by the Defendant, an admitted mistake by counsel for the Defendant in responding to interrogatory answers, as well as potentially contradictory testimony of the Defendant at the time of trial, constitutes good cause required by *Rule* 1.1007 to extend the timeframe permitted for the filing of a motion for new trial.

This Court is constrained by the specific requirements of *Rule* 1.1007 concerning the filing of a motion for new trial, as well as any extensions which may be granted. Iowa Courts have strictly construed *Rule* 1.1007 and extensions thereof. Iowa Courts have consistently held that motions requesting an extension of time for filing post-trial motions must be filed before the expiration of the original period for filing. The Motion seeking leave to extend the deadline for filing in this matter for the Supplemental Motion for New Trial was not filed until May 7, 2019 which is both after the filing of the Supplemental Motion for New Trial motion.

Without reaching a determination on the merits extended above, the Court finds that the Supplemental Motion for New Trial, as well as the Motion Seeking to Extend the Time to File the Supplemental Motion for New Trial were untimely and, therefore, the Court is without jurisdiction to address the issues raised in those Motions. The Plaintiffs filed the post-trial motion under I*owa Rule of Civil Procedure* 1.1004 (new trial) and *Rule* 1.1007 (time for motions and exceptions). As a result, the Court can only rule on the Motion as presently presented as a Supplemental Motion for New Trial.

For the reasons stated above, the Plaintiffs' Motion for New Trial is DENIED. The Plaintiffs' Supplemental Motion for New Trial is DENIED AS UNTIMELY.

<u>Clerk to send copies to</u>: Counsel of Record



State of Iowa Courts

Type: OTHER ORDER

Case NumberCase TitleLACV130355W & E MCGREWS VS E OTOADESE ET AL

So Ordered

Kellyann M. Lekar, Chief District Court Judge, First Judicial District of Iowa

Electronically signed on 2019-12-08 22:52:55 page 9 of 9

IN THE IOWA DISTRICT COURT FOR BLACK HAWK COUNTY

WILLIAM MCGREW and ELAINE)	
MCGREW,)	
)	NO. LACV130355
Plaintiffs,	Ś	
,	Ś	
VS.	5	
150	Ś	NOTICE OF APPEAL
	!!	
EROMOSELE OTOADESE, M.D.		
and NORTHERN IOWA)	
CARDIOVASCULAR AND)	
THORACIC SURGERY CLINIC,	Ś	
P.C.	K	
)	
	1	
Defendants		

TO: Clerk of District Court for Black Hawk County, the Clerk of the Supreme Court, and to Counsel for Defendants.

Notice is given that Plaintiffs William and Elaine McGrew appeal to the Supreme Court of Iowa from the final order filed on December 8, 2019 and from all adverse rulings and orders inhering therein, including the adverse jury verdict and entry of adverse judgment.

Dated: December 26, 2019.

Respectfully submitted,

/s/ Martin A. Diaz MARTIN A. DIAZ 000009676 ICIS AT0002000 1570 Shady Ct. NW Swisher, IA 52338 319-339-4350 telephone 319-339-4426 facsimile marty@martindiazlawfirm.com

MARK L. CHIPOKAS PC

By: <u>/s/ Mark L. Chipokas</u> Mark L. Chipokas, AT0001418 866 First Avenue NE P.O. Box 1261 Cedar Rapids, Iowa 52406-1261 (319) 366-7888 (888) 466-1350 Fax E-mail: <u>mark@mlchipokaspc.com</u>

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

The undersigned certifies a copy of this notice of appeal was served on the 26th day of December, 2019 upon the following persons and upon the clerk of the Supreme Court by EDMS (or by email upon the Court Reporters):

Jennifer E. Rinden Shuttleworth & Ingersoll 115 3rd St. SE, Suite 500 Cedar Rapids, IA 52401 JER@Shuttleworthlaw.com Attorney for Defendants

Brittani Meyer Court Reporter, First Judicial District brittani.meyer@iowacourts.gov

Amanda Lee Court Reporter, First Judicial District amanda.lee@iowacourts.gov

Clerk, Iowa Supreme Court Iowa Judicial Branch Bldg. 1111 East Court Avenue Des Moines, IA 50319 E-FILED 2019 DEC 26 8:26 AM BLACKHAWK - CLERK OF DISTRICT COURT

/S/Martin A. Diaz



September 26, 2014

RE: William McGrew DOB:

Ivo Bekavac, MD, PhD

1753 W. Ridgeway Avenue

Dept. of Neurology

Waterloo, IA 50701

FAX 319.833.5955

319.833.5954

Suite 112

Mr. William McGrew comes in self-referral as well as his family for second opinion about stroke.

HISTORY OF PRESENT ILLNESS: According to the patient and his family on August 5, 2014 he had episode of visual problem, describes everything was greying on his eye lasting between one to two minutes. No associated weakness involving any part of his body. He was otherwise healthy except hypertension. He went to see Dr. Mauer, who send him to see Dr. Otoadese and CTA was done of the extracranial circulation on August 18, 2014. It was read by Dr. Cammoun, who felt there was right ICA stenosis around 65%. I did review personally and showed to the patient and his daughter and son and my opinion stenosis of right ICA is Subsequently Dr. Otoadese performed right carotid artery approximately 40%. endarterectomy on September 2, 2014. Prior to the surgery patient was asymptomatic. He was not taking aspirin when this event occurred and was just started a week or so before the surgery. Extensive records reviewed around 60 pages. After surgery he was doing great and then very next morning around 7:10 it was noticed by nurse as well as his daughter the patient was confused and had left facial droop. Dr. Almullahassani, a neurologist was called who ordered CTA which apparently showed right ICA occlusion. CTA was done at 11:05 and symptoms started around 7:10 a.m. MRI of the brain showed acute right M2 territory ischemic infarct and some changes involving basal ganglia involving territory of the lenticulostriate arteries. Dr. Almullahassani requested second endarterectomy and clot removal. Apparently Dr. Otoadese was not willing to do so, but then Dr. Almullahassani according to the patient's daughter asked for opinion by Dr. Karimi, a vascular surgeon at Covenant Medical Center was about to transfer the patient, then finally Dr. Otoadese came back and performed right endarterectomy between 3:00 to 3:30 p.m. After the surgery the patient had complete weakness on the left side. Prior to that family is not sure whether he had any weakness involving his left hand at all. Also became confused and eyes were looking to the right side. He has been essentially the same since the second surgery. Repeat MRI done following day did reveal very similar area of infarction according to my review essentially unchanged from previous one done day before. The patient has been on aspirin for stroke prophylaxis 325 mg a day. Since the surgery he has been also complaining of lower back pain on the left side without shooting distally. No imaging of the lumbosacral spine. He has been doing stroke rehabilitation.

REVIEW OF SYMPTOMS: Complete review of (14) systems and complete past medical and social history was performed using the Medical Questionnaire dated and signed September 26, 2014. In addition to the above, no additional complaints.

William Mcgrew September 26, 2014 Page 2

PAST MEDICAL HISTORY: Hypertension.

SOCIAL HISTORY: He used to smoke one pack a day for 40 years, quit smoking 10 years ago. No alcohol.

FAMILY HISTORY: Father died at the age of 81 with myocardial infarction. Mother died at the age of 63, ALS.

ALLERGIES: None.

PRESENT MEDICATIONS: Medications were reviewed and can be found on the patient information sheet located in the chart.

PHYSICAL EXAMINATION: He is well developed and in no apparent distress.

Vitals: Blood pressure 120/84 with a heart rate of 78 and respiratory rate of 16.

HEENT: Head is atraumatic and normocephalic. Funduscopic examination not performed because of miosis. The rest of the ENT exam is normal.

Neck: Supple. No JVD and no carotid bruits. No lymphadenopathy.

Heart: Regular rhythm and rate. No murmur.

Lungs: Clear to auscultation and percussion.

Abdomen: Not examined.

Extremities: No clubbing, cyanosis or edema.

NEUROLOGICAL EXAMINATION:

Orientation: He was found to be awake, alert, and oriented X3.

Recent and Remote Memory: Normal.

Attention Span and Concentration: Normal.

Cranial Nerve exam: There is conjugate gaze preference to the right side, but he can pass midline all the way to the opposite side. No nystagmus. Rest of cranial remarkable for left facial weakness, central type except visual field not tested.

Motor Exam: Motor strength in left upper and lower extremities is 0/5, right side 5/5.

Sensory Exam: Intact to all modalities.

Reflexes: Brisk on the right side 3/4, left 3+/4. Plantar response in the left side is extensor, right is flexor. **Gait:** He is in a wheelchair, unable to walk

Language: Intact.

Fund of Knowledge: Normal.

Speech: Normal.

Test of Coordination: Finger-to-nose and heel-to-shin normal.

IMPRESSION:

- 1. The patient suffered right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery.
- 3. Right M2 territory embolic, artery-to-artery infarction. Not so much change in comparison to previous MRI of the brain.
- 4. Lower back pain might be discogenic versus musculoskeletal in etiology.

PLAN:

- 1. Continue aspirin 325 mg a day for secondary stroke prophylaxis.
- 2. Obtain an MRI of the lumbosacral spine.

William Mcgrew September 26, 2014 Page 3

- 3. I will ask Dr. Halloran, neuroradiologist to review CTA because of discrepancy between my review and Dr. Cammoun review. Also we will ask him to review MRI done on September 3, 2014 and September 4, 2014. I encouraged the patient and his family to be very engaged in stroke rehabilitation.
- 4. Reevaluate the patient in one month or earlier as needed.
- 5. The patient will be notified as well as his family regarding MRI findings.
- 6. Spent one hour with the patient and his family as well as reviewing records

Sekavac, M.D., Ph.D. IB/ts/wkm

E-FILED 2019 FEB 12 3:56 PM BLACKHAWK - CLERK OF DISTRICT COURT

IVO BEKAVAC, M.D., Ph.D.

ADDRESS:

Department of Neurology Cedar Valley Medical Specialists 1753 W. Ridgeway Avenue, Suite 112 Waterloo, IA 50701 E-mail: NEUROMARINA@AOL.COM

EDUCATION:

Medical school:University of Zagreb, Croatia
M.D., September 1989Ph.D.:University of Zagreb/Hahnemann University,
Zagreb/Philadelphia
Ph.D. in Neuroscience, April 1995

CLINICAL EXPERIENCE:

Internship - Clinical Hospital Split, Croatia, 1989-90 Internship - Cleveland Clinic, Cleveland, USA, 1994-95 Neurology residency program - Cleveland Clinic, USA, 1995-98 Staff Neurologist – Waterloo, USA, 1998- present

SPECIFIC TRAINING:

EEG/EP/Epilepsy -Cleveland Clinic, Cleveland, USA, 1996-98(6 months) **Minifellowship in Epilepsy** - Bowman Gray School of Medicine, 1997 **EMG course** -Cleveland Clinic, Cleveland, USA, 1997-98 (6 months) **Neurovascular ultrasound (carotid and TCD)**-Cleveland Clinic (1 month) **Neurovascular ultrasound course** - Bowman Gray School of Medicine, 1998

BOARD CERTIFICATION:

American Board of Psychiatry and Neurology - 2000 American Board of Electrodiagnostic Medicine - 2001 American Society of Neuroimaging – 2002 (MRI/CT & Neurosonology) Subspecialty Board in Vascular Neurology, ABPN – 2006 Neuroimaging Subspecialty Board, UCNS – 2013

RESEARCH EXPERIENCE:

Student - research program in clinical cardiology, Department of Cardiology, Clinical Hospital Split, Croatia, 1986-89 Post Doctoral Fellow - Department of Anesthesia Research, McGill University,

Post Doctoral Fellow - Department of Anesthesia Research, McGill University, Montreal, Canada, 1990-91:

-study of activated ion channels using patch clamp technique (neuroscience-electrophysiology) -study of speed of action of various muscle relaxants using iontophoresis

Research Associate, Department of Physiology, Hahnemann University, Philadelphia, USA, 1991-1994:

-effect of cocaine on the somatosensory signal processing using single unit extracellular recording (in vivo)

Resident-cerebrovascular clinical research, Cleveland Clinic, 1995-98

TEACHING EXPERIENCE:

Teaching Assistant-Department of Physiology, McGill University, 1990-91 ACLS Course Instructor -First Croatian World Congress, Croatia, 1996 Assistant professor of neurology- Medical School Split Adjunct associate professor of neurosurgery-University of Iowa Hospitals/Clinics

PROFESSIONAL MEMBERSHIP:

American Academy of Neurology, since 1997

LICENSURE:

- 1. **Iowa**, since 1998
- 2. **Ohio**, since 1995
- 3. Utah, since 1995

LIST OF PUBLICATIONS:

Papers:

1. Miric D, Rumboldt Z, Tonkic A, **Bekavac I.** (1989). Out-of-hospital sudden death rate: some peculiarities in circadian rhythm. **Medicina** 25:69-71.

- Rumboldt Z, Miric D, Bekavac I. (1988). The rhythm of dying due to heart stroke during the day. The Second Croatian Symposium on Cardiovascular Disease. 54:61-64.
- 3. Law Min JC, **Bekavac I**, Glavinovic MI, Donati F, Bevan DR. (1992). Iontophoretic study of speed of action of various muscle relaxants. **Anesthesiology** 77:351-356.
- 4. Bekavac I, Waterhouse BD. (1995). Systemically administered cocaine selectively enhances long-latency responses of primary sensory cortical neurons to peripheral stimuli. J. Pharmacol. Exptl. Therapeut. 272:333-342.
- 5. Waterhouse BD, Gould EM, **Bekavac**, I. (1996). Monoaminergic substrates underlying cocaine-induced enhancement of somatosensory evoked discharges in rat barrel field cortical neurons. J. Pharmacol. Exptl. Therapeut. 279:582-592.
- Bekavac I, Hanna JP, Wallace RC, Powers J, Ratliff NB, Furlan AJ, (1997). Intraarterial thrombolysis of myxomatous proximal middle cerebral artery occlusion. Neurology 49:618-620.
- 7. Bekavac I, Hanna JP, Sila CA, Furlan AJ. (1999). Warfarin and low-dose aspirin for stroke prevention in patients with severe intracranial stenosis. Journal of Stroke and Cerebrovasc. Diseases 8:33-37.
- 8. Bekavac I, Halloran JI. (2003). Meningocele induced positional syncope and retinal hemorrhage. AJNR 24:838-839.
- 9. Halloran JI, **Bekavac I.** (2004). Unsuccessful tissue plasminogen activator treatment of acute stroke caused by a calcific embolus. **J. Neuroimaging** 14:385-387.
- 10. **Bekavac I,** Halloran JI, Frazier S, Sprung J, Bourke DL. (2006). Chiropractic manipulation induced dissection and subsequent aneurysm formation of the internal carotid artery, or if it ain't broke, don't fix it. **J. Explore** 2:150-151.
- 11. Bekavac I, Goel S. (2011). Transient, unilateral, complete, oculomotor palsy in an adult patient with idiopathic intracranial hypertension. Signa Vitae 6(1): 44-46.

Abstracts:

- 1. **Bekavac, I.** (1989). Functional correlate between air pollution and heart disease. Medical Conference 35:1989.
- Law Min, J.C., Bekavac, I., Glavinovic, M.I., Donati, F. and Bevan, D.R. (1991). Iontophoretic study of speed of action of various muscle relaxants. Anesthesiology 75:A810.
- 3. **Bekavac, I.** and Waterhouse, B.D. (1992). Physiological actions of cocaine in sensory circuits: I. Enhancement of rat somatosensory cortical neuron responsiveness to vibrisae stimulation. Soc. Neurosci. Abstr. 18:544.
- 4. Waterhouse, B.D. and **Bekavac**, I. (1992). Physiological actions of cocaine in sensory circuits: II. Drug-induced alterations in receptive field properties of rat somatosensory cortical neurons. Soc. Neurosci. Abstr. 18:544.
- 5. Kapural, L., Bekavac, I., Trifaro, J.M. and Glavinovic, M.I. (1992). Effect of 4aminopiridine on bovine chromaffin cell membranes. Soc. Neurosci, Abstr. 18:794.
- 6. Waterhouse, B.D., Stowe, Z., Jimenez-Rivera, C.A. and **Bekavac, I.** (1992). Influences of cocaine on the response properties of single neurons in

monoaminergically-innervated sensorimotor circuits. Annual Meeting of Drug Abuse, Puerto Rico.

- 7. Waterhouse, B.D. and **Bekavac, I.** (1992). Cocaine effects on stimulus coding properties of sensory cortical neurons. Annual Meeting of Drug Abuse, Puerto Rico.
- Bekavac, I. and Waterhouse, B.D. (1993). Physiological actions of cocaine in sensory circuits: I. Identification of monoaminergic substrates underlying drug-induced enhancement of somatosensory evoked discharges in rat barrel field cortical neurons. Soc. Neurosci. Abstr. 19-1855.
- 9. **Bekavac, I.**, Rutter, J.J. and Waterhouse B.D. (1994). Physiological actions of cocaine in sensory circuits: drug influences on signal transmission through rat Pom and VPM thalamic nuclei. Soc. Neurosci. Abstr. 20:982.
- Bekavac, I., Wallace, R.C., Powers, J., Ratliff, N.B. and Hanna J.P. (1996). Intraarterial thrombolysis of myxomatous proxymal middle cerebral artery occlusion. First Croatian World Congress 1:12.
- 11. **Bekavac, I.,** Hanna, J.P. and Sila, C.A. (1997). Warfarin and low-dose aspirin for stroke prevention in patients with severe large arterial intracranial stenosis failing monotherapy. Neurology, 49:A289
- 12. Bekavac, I., Sethi, P., Wong, C.O. and Hanna, J.P. (1998). Utilizing stress Technetium-99m-ECD brain SPECT in the management of intracranial stenosis. Neurology, 50:A400

BOOK CHAPTERS:

Bekavac I, Pathophysiology of neurological diseases. In: Gamulin S, Marusic M. Pathophysiology, fourth edition, Zagreb: Mladost, 1998:830-860.

LECTURES:

Grand rounds, Cleveland Clinic, May 1998: Excitotoxicity and Stroke Clinical Neuroscience Course, University of Split, June 2000 Clinical Neuroscience Course, University of Split, July 2002



October 30, 2014

RE: William McGrew DOB:

Ivo Bekavac, MD, PhD Dept. of Neurology

⁷53 W. Ridgeway Avenue Suite 112

Waterloo, IA 50701

319.833.5954

FAX 319.833.5955

Mr. William McGrew comes in for followup regarding stroke as well as lower back pain. He had MRI of the lumbosacral spine read by Dr. Halloran, reviewed personally and showed to the patient. It is remarkable for lateral disc herniation at the level L3-L4 as well as disc bulging at the level L3-L4 as well as L4-L5. Dr. Halloran did over read CTA and felt that there is ICA stenosis of 32%. While doing physical therapy he is doing better, also he has been doing stroke rehabilitation. He has not noticed any improvement. On examination, there is a complete weakness involving left upper and left lower extremity 0/5 unchanged since initial examination September 26, 2014. He has been also complaining of being depressed and also noticed by his family as well. List of medications reviewed. He is not taking any antidepressants. Apparently, he is on clopidogrel as well as aspirin 81 mg for stroke prophylaxis.

IMPRESSION:

- 1. Status post right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery. Initial carotid artery stenosis 32% according to Dr. Halloran.
- 2. Intermittent lumbar sensory radiculopathy with symptomatic improvement. No evidence of lumbosacral motor radiculopathy.
- 3. Depression.

PLAN:

- 1. Continue with clopidogrel 75 mg a day as well as aspirin 81 mg a day for secondary stroke prophylaxis.
- 2. Continue physical therapy and stroke rehabilitation.
- 3. Star the patient on Lexapro 10 mg a day for depression. Potential side effects were explained to the patient as well as his family.
- 4. Reevaluate the patient in two months or earlier as needed.
- 5. Multiple questions were answered.

Vo Bekavac, M.D., Ph.D.

IB/ts/wkm

McGrew, William M (MR # 92371812) DOB: 05/30/1945

Radiology Results (10/09/14 - 10/01/14) (continued)

Xray consultation referred [136743188] (continued)

Resulted: 10/09/14 1426, Result status: Final result

Ordering provider: Performed: Narrative:	Ivo Bekavac, MD 10/01/14 1303 - 10/01/14 1423	Resulted by: Resulting lab:	John I Halloran, MD UPH ALLEN MEMORIAL SUNQUEST RAD			
	MCGREW, WILLIAM M Or 1532 HAWTHORNE ST PT	epartment der No:14AMR3576 ⁻ . LOC: MIT HX:				
	PHONE ADMITTING DR: BEKAVAC, IVO MD ORDERING DR: BEKAVAC, IVO MD ATTENDING DR: CC: THIS COPY T MEDICAL RECORD NUMBER: 92371812 Exam Date:10/0 PROCEDURE(S): MR SPINE LUMBAR WO CONTRAST USUAL	DOCUMENT STATUS: Fina	I			
	REASON FOR EXAM: low back pain					
	TECHNIQUE: Multiplanar, multisequence ir performed.	naging of the lumbar spine				
	CLINCAL HISTORY: see above REASON FOR EXAM					
	CORRELATION: None available.					
	FINDINGS:					
	L1-2 level: Negative					
	L2-3 level: Negative					
	L3-4 level: Slight disc space narrowing. Very broad-based far right lateral disc herniation. Protruding disc fills inferior recess the right neural foramen and closely approximates right L3 nerve. Moderate bilateral degenerative facet arthropathy. Mild spinal canal stenosis.					
	L4-5 level: Moderate bilateral degenerative f spondylolisthesis, symmetric disc bulge, mo and small endplate osteophytes. Mild spina neural foraminal stenosis.	derate disc space narrowing				
	L5-S1 level: Mild bilateral degenerative facet arthropathy.					
	IMPRESSION: 1. L3-4 level far right lateral disc herniation, stenosis and moderate bilateral degenerativ 2. L4-5 level degenerative facet arthropathy mild spinal canal and bilateral neural foramin	e facet arthropathy. , spondylolisthesis, and				
	Signed by: John I Halloran MD on 10/1/2014 2:56 PM Report created with Powerscribe 360					
	ALLEN MEMORIAL HOSPITAL, WATERL MCGREW,WILLIAM M MR SPINE LUMBAR WO CONTR I	OO IA. PAGE 2 of 2 DOCUMENT STATUS: Final				
pecimen Collection Type	Source	Collected On				

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
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Northern Iowa Cardiováscular & Thoracic Surgery Clinio, P.C. REGISTRATION FORM	
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Student Information: X Not a Student Yes, IF yes: Full time Part time	ក្នុងនេះ និង នេះ នេះ នេះ នេះ នេះ នេះ នេះ និង
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Who will be responsible for your account? X self Spouse Father If not self, please complete: Name	the second s
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For Patient's under the age of 18: Pather's Name: Address: Braployer: Employer:	
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I authorize you to give mis reasonable and proper middleal care by today's standards, I authorize Northern Lows Cardiovascular & Thoraclo Surgery Clinic, P.C. to rolease any medical information necessary to p I authorize Northern Lows Cardiovascular & Thoraclo Surgery Clinic, P.C. to rolease any medical information necessary to p I authorize Northern Lows Cardiovascular & Thoraclo Surgery Clinic, P.C. I authorize Northern Lows Cardiovascular & Thoraclo Surgery Clinic, P.C. I authorize that is m responsible for any balance due on my suscount. I authorize that a copy of this information to be availed as the original. Signature: & -1 & -14	DEFENDANT'S

Northern Iowa Cardiovascular 001

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Northern Iowa Cardiovascular & Thoracic Surgery Clinic PC 146 West Dale St #202 Waterloo, IA 50703 319-233-6211

OFFICE VISIT

DATE:08-30-2016

NAME: Willam McGrew DOB: Concentration DOS: 08/20/2014

SUBJECTIVE: Patient is here for follow up. He underwent OTA of the carolid arteries as part of the work up of right eye visual disturbance. He is here to review the results of the study and discuss further management.

OBJECTIVE: The CTA showed at least 70% stenosis of the right ICA by a complex plaque. The left ECA is 80% stenotic at the origin. Patient has not reported recurrent symptoms since his lest office visit last week.

ASSESSMENT: Symptomatic right ICA atenosis.

Active Medical Problems: * Carolid Artery Stenosis

Smoking Status: ; Received Cessation Intervention-No

PLAN: Based on his symptoms and the findings of the CTA I recommend right ICA intervention. The options of CEA vs CAS were discussed with the patient and his daughter who was with him during this office visit. In the end patient has elected the CEA. The procedure was described to him and all questions were answered. He will call our office to schedule the right CEA at his convenience.

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Eromosele Otoadese, MD

This letter has been auto-generated from our electronic system for expediency and may reflect the nature of such a computer generated report.

REFERRING: John Musgrave MD FAX#: 319-235-5013 SECONDARY: FAX: PRIMARY: John Musgrave MD FAX: 319-235-5013

Patient ID: 127877 McGrew, William DOB:1945-05-30 EXAM SOAP Note Office

08/23/2016 12:43:48 Page 1/1

Northern Iowa Cardiovascular 006

Northern Iowa Cardiovascular & Thoracic Surgery Clinic PC 146 West Date St #202 Waterloo, IA 50703 319-233-8211

CONSULTATION DATE: 08-28-2014

PATIEN I NAME: William McGrew D.O.B: Schemes PCP: John Musgrave MD REFERRING PHYSICIAN/PROVIDER: John Musgrave MD DOS: 08/18/2014

PATIENT IS HERE FOR (HX): Patient has no previous history of strokes or carotid anery disease. He relates that he had an episode of transient loss of vision in the right eye several days ago. The spisode lasted about a minute and has not recurred. As part of the workup a carotid duplex ultrasound was performed at an outside facility. The study showed 50% stenosis of the bilateral ICAs and critical stenosis of the bilateral ECAs. Patient is now referred to our clinic for further evaluation and management.

CHIEF COMPLAINT: Patient complains of carotid stenosis.

ALLERGIES: NKDA,

MEDICATIONS: HCTZ Dexilant Aleve Flomax Fish oll

PAST MEDICAL HISTORY: Hypertension, GERD, Arthritis, Carolid artery stenosis,

PAST SURGERIES: Denles.

FAMILY HISTORY (BLOOD RELATIVES ONLY): Father, deceased: Mi, Mother, deceased: Lou Gehrig's. 3 brothers, alive: healthy. 5 sisters, alive: cirrhosis(alcohol). 1 brother, deceased: Mi, 4 children elive: breast cancer.

SOCIAL HISTORY: Smoking: Former Smoker Alcohol: never Caffelne: average

RISK FACTORS: age, blood pressure, hypertension

REVIEW OF SYSTEMS: Hearing Ald, Increased/Excessive Urine, Difficulty Urinating, Urine Frequency, Night Sweats, Dentures, Arthritis, Joint Pain, Weakness, Neck Pain, Numbness, Neurological Weakness as above otherwise: Constitutional: No fevers, chills, or significant weight loss, Eyea: No double vision, blurry vision or diplopla. Cardiac: No chest pain, paipliation or or frophea. Respiratory: No SDB, cough or wheezing. Gastrointestinal: No abdominal pain, vomiting, diarrhea, heartburn or jaundice. Genitourinary: No hematuria, polyuria, incontinence. Psychosocial: No anxiety, depression or bipolar disorder.

VITALS: Height: 66 Inches Weight: 192.2 ibs BMI: 31.019 Pulse: 58 Blood Pressure: 134/68

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Patient ID: 127877 McGrew, William DOB:1945-05-30 EXAM Male H&P

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Northern Iowa Cardiovascular 007

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4006 Johnethen Street • Waterloo, Iowa • 50701 Phone: 319-236-2700 • Toll Free: 877-ADI-5345 • Fax: 319-236-2714 www.ADioflows.com

Technologist:

Name WILLIAM M MCGREW Phone: (319) 232-2922 DOB: Dob: Date of Exam: 8/18/2014 Ordering Physician: EROMOSELE A. OTOADESE MD

JOHN MUSGRAVE MD

PROCEDURE: CT ANGIOGRAM OF THE NECK WITH CONTRAST

COMPARISON: None.

INDICATIONS: Carotid stenosis, Visual disturbance. Having Cataract surgery on Wednesday,

HISTORY: 69 year old male with visual disturbance.

TECHNIQUE: Multislice spiral CT angiography was obtained from the level of the aortic arch through the skull base during IV administration of 80ml Isovue 370. Transaxial, parasagittal and coronal images were obtained and the exam was reviewed on a physician 3-D vitrea workstation.

FINDINGS/IMPRESSION:

Brachlocephalic artery: No significant luminal narrowing.

Subclavian arteries:

Right side: Tortuosity proximally without hemodynamically significant narrowing.

Left side: Tortuosity in the proximal segment, No luminal stenosis.

Vertebral arterles:

Right side: Segment 1: Unremarkable. Segment 2: Patent. Segment 3: Patent. Segment 4: Lerge plaque distally with near occlusion of the proximal third of segment 4.

Left side: V1:Tortuous. V2: Patent, V3: Atherosclerotic disease without significant narrowing. V4: Patent.

Basilar artery: Patent.

Carotid system:

Right side:

CCA: Tortuousity proximally.

Distal segment demonstrates atherosclerotic disease distally extending into the ICA bulb without evidence for significant luminal stenosis,

ICA bulb: Calcified and noncalcified plaque identified leading to a luminal stenosis at the proximal ICA bulb, diameter 1.9mm. The length of the narrowing is approximately 8.8mm. The normal luminal diameter of the postbulbar ICA is approximately 5.2mm. Normal diameter of the distal CCA is 7.9mm. This leads to approximately 65% luminal stenosis compared with the distal vessel (postbulbar ICA). The postbulbar ICA is otherwise patent.

Continued Report - Page 2 of 2

Name WILLIAM M MCGREW Phone: (319) 232-2922 DOB: Control Contr Ordering Physiolan: EROMOSELE A, OTOADESE MD

JOHN MUSGRAVE MD Technologist: Amber Niemann RT(R) (MR)

. The Intracranial ICA: Patent.

Atherosclerotic disease of the intracavernous ICA without significant narrowing.

ECA: No significant luminal stenosis.

Left side:

CCA: Tortuosity in the proximal segment.

Atheroscierotic disease distally.

ICA bulb: Alherosclerotic disease involving the ICA bulb without luminal stenosis.

Postbulbar ICA: There is no significant luminal narrowing.

Intracranial ICA: Atherosclerotic disease without significant luminal narrowing in the intracavernous portion of the ICA.

ECA: There is severe luminal stenosis at the origin of the ECA leading to about 80% luminal stenosis.

Non CTA findings: Small nonspecific bilateral thyroid nodules. Parotid glands unremarkable. Submandibular glands unremarkable. No lymphadenopathy or mass. Airway is patent.

Diclated by: Driss Cammoun, M.D. on 8/18/2014 at 15:28 Transcribed by: BUCK on 8/18/2014 at 15:52 Approved by: Driss Cammoun, M.D. on 8/19/2014 at 9:45

Northern Iowa Cardiovascular 038

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September 26, 2014

RE: William McGrew DOB:

Mr. William McGrew comes in self-referral as well as his family for second opinion about stroke.

HISTORY OF PRESENT ILLNESS: According to the patient and his family on August 5, 2014 he had episode of visual problem, describes everything was greying on his eye lasting between one to two minutes. No associated weakness involving any part of his body. He was otherwise healthy except hypertension. He went to see Dr. Mauer, who send him to see Dr. Otoadese and CTA was done of the extracranial circulation on August 18, 2014. It was read by Dr. Cammoun, who felt there was right ICA stenosis around 65%. I did review personally and showed to the patient and his daughter and son and my opinion stenosis of right ICA is approximately 40%. Subsequently Dr. Otoadese performed right carotid artery endarterectomy on September 2, 2014. Prior to the surgery patient was asymptomatic. He was not taking aspirin when this event occurred and was just started a week or so before the surgery. Extensive records reviewed around 60 pages. After surgery he was doing great and then very next morning around 7:10 it was noticed by nurse as well as his daughter the patient was confused and had left facial droop. Dr. Almullahassani, a neurologist was called who ordered CTA which apparently showed right ICA occlusion. CTA was done at 11:05 and symptoms started around 7:10 a.m. MRI of the brain showed acute right M2 territory ischemic infarct and some changes involving basal ganglia involving territory of the lenticulostriate arteries. Dr. Almullahassani requested second endarterectomy and clot removal. Apparently Dr. Otoadese was not willing to do so, but then Dr. Almullahassani according to the patient's daughter asked for opinion by Dr. Karimi, a vascular surgeon at Covenant Medical Center was about to transfer the patient, then finally Dr. Otoadese came back and performed right endarterectomy between 3:00 to 3:30 p.m. After the surgery the patient had complete weakness on the left side. Prior to that family is not sure whether he had any weakness involving his left hand at all. Also became confused and eyes were looking to the right side. He has been essentially the same since the second surgery. Repeat MRI done following day did reveal very similar area of infarction according to my review essentially unchanged from previous one done day before. The patient has been on aspirin for stroke prophylaxis 325 mg a day. Since the surgery he has been also complaining of lower back pain on the left side without shooting distally. No imaging of the lumbosacral spine. He has been doing stroke rehabilitation. The patient wants to know exactly the reasoning behind surgery whether first surgery and second surgery was indicated.

REVIEW OF SYMPTOMS: Complete review of (14) systems and complete past medical and social history was performed using the Medical Questionnaire dated and signed September 26, 2014. In addition to the above, no additional complaints.

HIBIT

PLAINTIFFS' EXHIBIT 11

Ivo Bekavac, MD, PhD

Dept. of Neurology

1753 W. Ridgeway Avenue Suite 112 Waterloo, IA 50701 319.833.5954 FAX 319.833.5955 William Mcgrew September 26, 2014 Page 2

PAST MEDICAL HISTORY: Hypertension.

SOCIAL HISTORY: He used to smoke one pack a day for 40 years, quit smoking 10 years ago. No alcohol.

FAMILY HISTORY: Father died at the age of 81 with myocardial infarction. Mother died at the age of 63, ALS.

ALLERGIES: None.

PRESENT MEDICATIONS: Medications were reviewed and can be found on the patient information sheet located in the chart.

PHYSICAL EXAMINATION: He is well developed and in no apparent distress.

Vitals: Blood pressure 120/84 with a heart rate of 78 and respiratory rate of 16.

HEENT: Head is atraumatic and normocephalic. Funduscopic examination not performed because of miosis. The rest of the ENT exam is normal.

Neck: Supple. No JVD and no carotid bruits. No lymphadenopathy.

Heart: Regular rhythm and rate. No murmur.

Lungs: Clear to auscultation and percussion.

Abdomen: Not examined.

Extremities: No clubbing, cyanosis or edema.

NEUROLOGICAL EXAMINATION:

Orientation: He was found to be awake, alert, and oriented X3.

Recent and Remote Memory: Normal.

Attention Span and Concentration: Normal.

Cranial Nerve exam: There is conjugate gaze preference to the right side, but he can pass midline all the way to the opposite side. No nystagmus. Rest of cranial remarkable for left facial weakness, central type except visual field not tested.

Motor Exam: Motor strength in left upper and lower extremities is 0/5, right side 5/5.

Sensory Exam: Intact to all modalities.

Reflexes: Brisk on the right side 3/4, left 3+/4. Plantar response in the left side is extensor, right is flexor. **Gait:** He is in a wheelchair, unable to walk

Language: Intact.

Fund of Knowledge: Normal.

Speech: Normal.

Test of Coordination: Finger-to-nose and heel-to-shin normal.

IMPRESSION:

- The patient suffered right hemispheric embolic infarct after endarterectomy and occlusion of right internal carotid artery. Initially symptoms possibly related to amaurosis fugax, but 40% of stenosis was not significant to justify endarterectomy in my opinion.
- 2. In my opinion second endarterectomy probably was not indicated particularly being done after almost eight hours after the new onset of symptoms.
- Right M2 territory embolic, artery-to-artery infarction. Not so much change in comparison to previous MRI of the brain.
- 4. Lower back pain might be discogenic versus musculoskeletal in etiology.

PLAN:

- 1. Continue aspirin 325 mg a day for secondary stroke prophylaxis.
- 2. Obtain an MRI of the lumbosacral spine.

PLAINTIFFS' EXHIBIT 11

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William Mcgrew September 26, 2014 Page 3

- I will ask Dr. Halloran, neuroradiologist to review CTA because of discropancy between my review and Dr. Cammoun review. Also we will ask him to review MRI done on September 3, 2014 and September 4, 2014. I encouraged the patient and his family to be very engaged in stroke rehabilitation.
- 4. Reevaluate the patient in one month or earlier as needed.
- 5. The patient will be notified as well as his family regarding MRI findings.
- 6. Spent one hour with the patient and his family as well as reviewing records

Jekavac, M.D., Ph.D. IB/ts/wkm

PLAINTIFFS' EXHIBIT 11

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Page 1 of 1

McGrew, William M (MR # 92371812) DOB: 05/30/1945

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consultation referred		//05/14 - 10/01/14/	Resulted: 10/09/14 1426, Result status: Final res
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	Allen Memorial Hospital General X-ray MCGREW,WILLIAM M Order No:14AI 1532 HAWTHORNE ST PT. LOC: WATERLOO, IA 50702 ADMIT HX:	RA24244	
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	OR READING		
	REASON FOR EXAM:visual disturbance reading of or	utside films	
	CONSULTATION/REVIEW OF OUTSIDE FILMS:		
	I have been consulted to review a CT angiogram perforn McGrew at ADI on August 18, 2014. The examination v 3-D physician workstation. Volume rendered and maxin projection images were generated and reviewed	vas reviewed on a	
	FINDINGS: Aortic arch: Type II aortic arch. Minimal calcific atheros aortic arch. Minimal atherosclerosis in origin of the left c carotid artery without a hemodynamically significant nar of the right innominate and left subclavian arteries widel	ommon rowing. Origin	
	Right carotid: Small focus of calcific atherosclerosis at the of ICA producing a 32% diameter stenosis. The post bu ICA is widely patent.		
	The minimal right ICA diameter measures 3.2 cm. Post ICA diameter measures 4.7 cm	bulbar normal	
	Left carotid: Heterogeneous atherosclerosis of the carot producing 22% maximal lumen diameter stenosis of the The post bulbar cervical ICA is widely patent. Circumfe noncalcified moderate stenosis of origin of ECA.	proximal ICA.	
	The minimal left ICA diameter measures 4.2 mm. Post lumen diameter measures 5.4 cm.	bulbar normal ICA	
	Vertebrals: Short segmental heterogeneous atheroscler producing near occlusive narrowing of the distal right ve artery and focal noncalcific moderate stenosis of the dis vertebral artery.	ertebral	
	dso		
	Signed by: John I Halloran MD on 10/9/2014 2:23 PM Report created with Powerscribe 360		EXHIBIT
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PLAINTIFFS' EXHIBIT 13

CERTIFICATE OF SERVICE AND FILING

The undersigned certifies a copy of the Appendix was filed and served through the Electronic Document Management System on all counsel of record and the Clerk of Supreme Court.

/s/ Martin A. Diaz_____

CERTIFICATE OF COST

I further certify that, because of use of EDMS, there was no cost associated with the printing and reproduction of this Appendix.

/s/ Martin A. Diaz____